

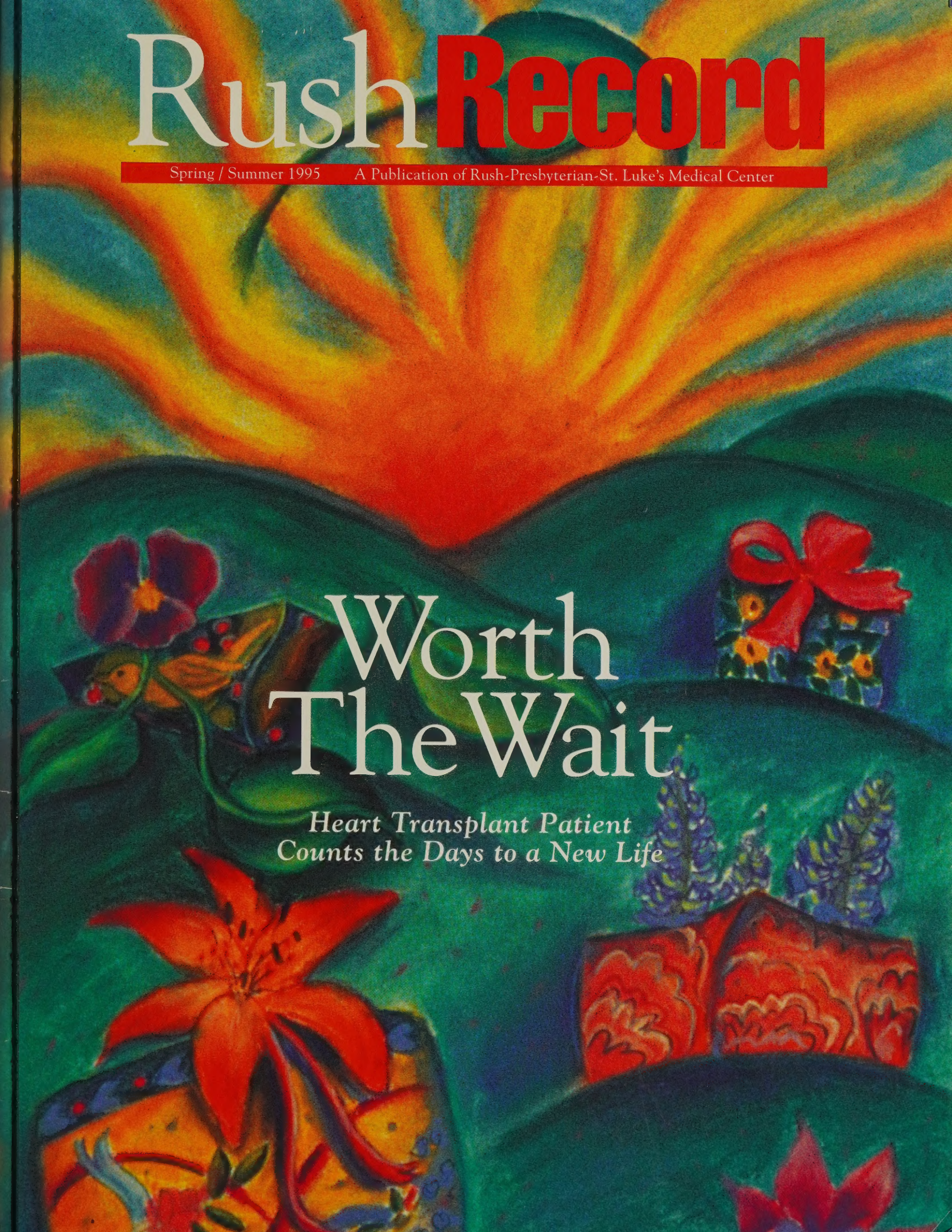
Rush **Record**

Spring / Summer 1995

A Publication of Rush-Presbyterian-St. Luke's Medical Center

Worth The Wait

*Heart Transplant Patient
Counts the Days to a New Life*



RushRecord

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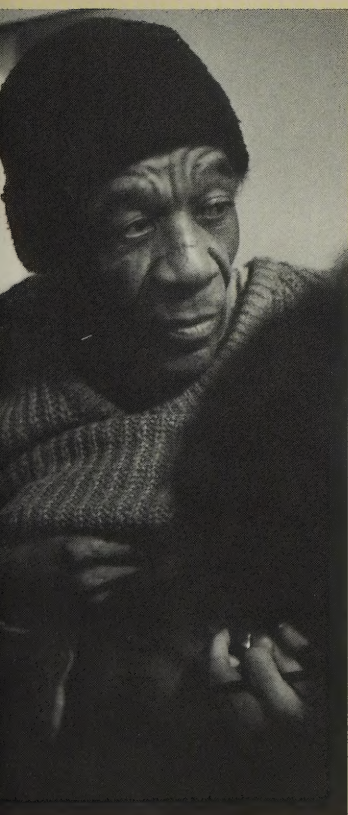
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WORTH THE WAIT

■ by Jeffrey B. Meyers

Sandra Nawracaj is content. Sitting in a recliner in the family room of her Glen Ellyn home, she reads a worn copy of *Snow White and the Seven Dwarfs* to the four grandchildren gathered around her. Later, she teaches them to bake a cake and plays games on the living room carpet. Like all doting grandparents, Nawracaj, 54, relishes the time she has with her grandchildren. But to her, each sentence she reads, each game she plays, each laugh and each smile bring even greater joy.

UNTIL JUST A FEW MONTHS AGO, SHE FEARED THAT EACH VISIT WITH THEM MIGHT BE HER LAST.

All that changed October 2, when Nawracaj's "broken heart," as her six-year-old granddaughter called it, was replaced with a healthy donor heart by a surgical team from the Rush Heart Institute. For Nawracaj, the transplant ended two years spent physically and emotionally exhausted, fearing that she would die waiting for a replacement heart.

Now, her life is very much the same as it was before the 1990 heart attack that led to her congestive heart failure. Back are the energy and stamina once stolen by her failing heart. And the emotional roller coaster, driven by fear, hope, and uncertainty, is, for the most part, over.

"While I was waiting for my heart," Nawracaj reflects, "I did a lot of thinking about whether I'd be around for next Christmas or for my next birthday. The question was always in the back of my mind."

When Nawracaj was told she needed a new heart, she was also told that she might wait more than a year for a transplant.

"Unfortunately, Sandy's case is not unique," says Maria Rosa Costanzo, MD, medical director of the Institute's Heart Failure and Cardiac Transplant Program. "It reflects the tremendous problem we have with donor shortages nationwide."

For every patient who gets a heart each year, another remains waiting. And some don't make it: Approximately

one-third of heart transplant patients in the U.S. die while waiting for a heart.

When donor hearts become available, they go to those ranked highest on a list kept by the United Network for Organ Sharing. Patients' ranking on the list is based on their condition and how long they have been waiting for a heart.

The list is constantly changing: Some patients get sicker and move up the list, while others improve and move down. There's no telling from day to day who will be next in line for a donor heart.

Because of what can prove to be a long wait, doctors do everything they can to treat a patient's failing heart until he comes to the top of the transplant list.

The congestive heart failure that Nawracaj and millions of other Americans

To combat the condition, patients are prescribed a cocktail of medications that are closely monitored and adjusted for maximum benefit. Nawracaj was given diuretics to help relieve swelling and reduce strain on her heart, blood thinners to prevent clotting, and other drugs to block the body's natural production of angiotensin, which constricts blood vessels.

As often as every four weeks, Nawracaj was checked by doctors and had her medications adjusted, if necessary. This regular fine-tuning helps some heart patients remain healthy enough to stay out of the hospital. But Costanzo says that most aren't so lucky.

"Because of the donor shortage and the long waiting time, most patients get sick enough to require life support in an intensive care unit until they can get a new heart."

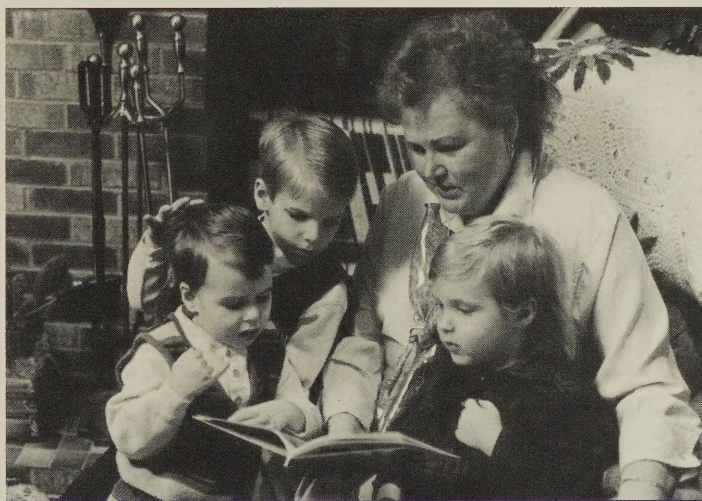
What may have helped keep Nawracaj out of the hospital is the experimental drug Vesnarinone. About a year after she was put on the transplant list, Nawracaj agreed to participate in a study of the drug involving more than 3,000 heart failure patients at Rush and other hospitals nationwide.

Preliminary results indicate that the drug may improve the pumping function of the heart and block the body's production of harmful substances during advanced heart failure, Costanzo says. Nawracaj says she began to feel less tired and could breathe more easily a few months after starting the drug in September 1993.

"She would probably have had to be hospitalized if she had not taken the drug," Costanzo says. "Her improvement was gradual, but it was substantial."

Costanzo says other patients have shown similar improvement while on Vesnarinone, which is available only at centers like Rush involved in its study.

Even while on Vesnarinone, however, Nawracaj was unable to keep the brisk pace she had enjoyed prior to her heart



Nawracaj enjoys a quiet moment with her grandchildren.

suffer causes the heart to lose its ability to maintain normal blood circulation, resulting in weakness and fatigue.

While most cases can be treated with medications and changes in diet and lifestyle, some, like Nawracaj's, are severe enough that a heart transplant is the only option.

Nawracaj's heart gradually became inefficient as the increasing volume of blood in her veins caused them to dilate. As the condition worsened, her lungs, liver and intestines became congested with blood, leaving her short of breath.

While Nawracaj's heart failure was caused by a heart attack, the condition can also result from diseases of the heart muscle and valves, high blood pressure, chronic lung diseases like emphysema, and viral illness, among other causes.

problems. Weakness, fatigue and shortness of breath served as constant reminders of her heart failure.

"She couldn't lift up my little boy anymore," her son, Ron Pendzinski, recalls. "That was really hard for her."

"I worried a lot that I wasn't going to make it," Nawracaj says. "But I tried to keep my head up and be strong, for both me and my family."

Mike Levick, MSW, a social worker with the Rush transplant program, says the

patients' families are also available.

"It's a difficult time for families, who often have to watch their loved ones deteriorate in front of their eyes," Levick says.

Nawracaj says talking to people who had received new hearts and were leading healthy lives helped her get through some tough times. "What a feeling it was to meet these people and think, 'they made it, so can I,'" she says.

After dealing with these emotions for two years, the Nawracajs won't soon forget the early morning phone call that announced that the wait was over. "I don't think they ever had a patient as happy to hear it was time for surgery," Nawracaj says.

William Piccione, MD, surgical director of the Rush transplant program, removed Nawracaj's frail heart and replaced it with a healthy donor heart.

"Her heart was enlarged and beating very weakly," Piccione said. "It was in pretty bad shape."

In just four hours — the time it took to remove the donor heart and transplant it — Nawracaj had been given another chance at life.

But the fight wasn't quite over. Like all transplant patients, she had to adapt to her newfound health, a process that can be difficult for some transplant patients.

"Sometimes it takes a while to get out of the sick role and begin resuming a normal life," Levick says. Patients are encouraged to take on more responsibilities around the home, and family members are instructed to let patients do more for themselves.

Side effects of post-transplant medications can also affect a patient's mood and self-esteem. Several anti-rejection drugs, which suppress the immune system to help the body accept its new heart, can cause physical and emotional changes such as increased hair growth, weight gain, a swollen face, acne, a humped back and mood swings. These side effects subside as dosages are reduced.

While patients are encouraged to be active, they must be careful of infection since they are taking immunosuppressive drugs. About every three weeks, Nawracaj undergoes a biopsy and other tests to insure that her body is not attacking the tissue of her new heart.

Rejection most often occurs in the first year following a transplant. However, recent improvements in anti-rejection drugs are making it less common. About

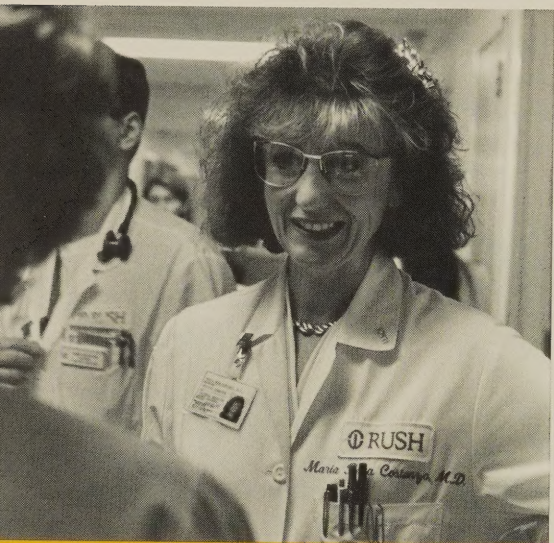
75 percent of heart transplant recipients survive at least three years after surgery, and many for much longer, according to the United Network for Organ Sharing.

Now, some eight months after her surgery, Nawracaj says she's getting stronger each day. She attends support group meetings regularly and plans to become a mentor. "I can relate to what heart patients are going through and maybe help someone else through this," she says.

Her family and friends say the vigor that she had prior to her heart attack has returned. "It's like a weight has been lifted from her shoulders," says her husband, Dennis. "There's quite a sense of relief around here."

For the first time in years, Nawracaj is secure in knowing that she will be there for her family. Now she's concentrating on making up for lost time. She's already making plans to fly to California to visit her eight-month-old grandson.

"I'm very lucky to have been given this chance to watch my grandkids grow up and to do things that I couldn't do before, because I was sick," she says. "I got my life back." ■



Maria Rosa Costanzo, MD

physical limitations imposed by heart failure lead patients to feel they have lost control over their lives. These feelings are compounded by fear that they will die before they get a transplant.

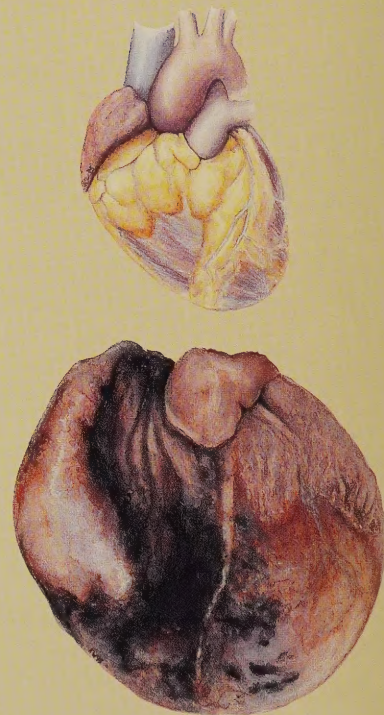
Patients also have to deal with the difficult issue of receiving someone else's heart, Levick says.

To help them cope with their illness, patients are encouraged to lead as much of a normal life as possible while on the waiting list. "We want the patient to feel he is in control of the disease—not that the disease is controlling him," Levick says.

But this can be difficult. To help, the Rush transplant program organizes support groups where patients waiting for a transplant can meet others like them, as well as talk to those who have already received a healthy heart. Levick is also establishing a mentor program that would enable post-transplant patients — with proper training — to provide one-on-one support to patients waiting for a heart.

Support services for transplant

Healthy vs. Diseased Heart



A healthy heart (top) becomes grossly enlarged and loses its ability to function with heart disease (bottom).

Illustration: Kristen Wienandt

THE GIFT OF LIFE

Occasionally, when Ron Pendzinski had reason to remove his driver's license from his wallet, he would glance at the Uniform Donor Card on the back. And each time, he would return it to his wallet unsigned.

That is, until his mother, Sandra Nawracaj, was told she would die without a heart transplant. Now he — and his three brothers and sister — have had a change of, well, heart.

"Having it hit so close to home really makes you think about it," says the Glendale Heights man. "For someone to help my mom like that — it made me realize that I could help someone, too."

Unfortunately, not enough people share Pendzinski's feelings. A shortage of donors has resulted in most transplant patients waiting more than a year for a donor heart.

The good news is 2,299 people nationwide received heart transplants in 1993, thanks to organ donors. The bad news is, by the end of the year, the national United Network on Organ Sharing (UNOS) still had 2,834 patients on the waiting list for donor hearts. And many don't survive the wait: 762 people died in 1993 while in line for a heart.

Ignorance and fear are the greatest obstacles to increasing the donor pool, says Mike Baker, RN, procurement coordinator for the Rush Heart Failure and Cardiac Transplant Program.

Contrary to widespread belief, donating organs does not interfere with funeral plans or disfigure the donor's body. The donor's family does not pay costs associated with donating organs.

Organ donation works this way: After a patient has been declared brain dead by a doctor, the body is kept alive using life-support systems. The most viable candidates for organ donation are those who have died suddenly, yet whose organs remain healthy, such as victims of car accidents, strokes and homicides.

The hospital staff then asks the family if they would consider organ donation. The Uniform Donor Cards on the back of Illinois driver's licenses may help a victim's family

make a decision, but that is where the card's significance ends.

"A family always has the last word on donating their loved one's organs," Baker says. "For that reason, and because your donor card might be lost, the most important step to becoming a donor is to tell your family."

When a donor heart is available, regional organ banks work on finding a matching recipient in the area. If a donor heart is in Illinois, for example, the Regional Organ Bank of Illinois (ROBI), which covers this state and part of Indiana, turns to a list of patients kept by UNOS. The list ranks patients based on their condition and how long they've been waiting for a heart. If ROBI can't find a match in this area, it looks to other regions.

A donor and recipient are matched by body weight and blood type. Race and sex don't matter.

When a match is found, the hospital serving the transplant patient races to collect the heart. Time is critical, since doctors generally have only four hours from the time blood flow is stopped to transplant the heart.

Because of the urgency, Baker often finds himself, picnic cooler in hand, aboard a Lear jet or helicopter on his way to collect a heart. He and doctors from the Rush transplant team examine the donor heart to insure that it is healthy before bringing it back to Rush, where a patient will be waiting for surgery.

"The Rush transplant team will travel to examine hearts that other hospitals may decline because of distance or the chance that the heart might not be suitable," Baker says. "Because of this extra effort, Rush transplant patients on average spend less time waiting for a donor heart than patients in other programs."

To educate people about donating organs, Baker meets regularly with civic, school and church groups.

"We're trying to change the perception surrounding organ donation," he says. "I don't know of any other gift that is given truly as a donation, with no strings attached." ■



This summer, Sue Wells will be there to watch as her backyard comes to life.

NEW

"I'm feeling so good I forget I'm still fighting a life-threatening illness," says the Northbrook wildlife expert, who spent much of last summer away from flower beds and birdfeeders, battling a cancer that nearly killed her.

In February 1994, Wells was diagnosed with acute myelogenous leukemia, a cancer that affects the soft tissue inside bones — the marrow — where blood cells are produced. Hers is a particularly deadly form of leukemia that eludes cure with standard treatments and kills more than half of its victims within a year.

But at the Rush Cancer Institute, Wells was offered the chance to receive a new treatment that combines vitamins and other natural disease-fighters with standard chemotherapy. By August, her cancer was in remission.

For decades, physicians have assailed cancer head on, cutting it from the body with surgery, killing it with chemotherapy, destroying it with radiation, or overwhelming it with a combination of the three. And thanks to these tactics, nearly half of the Americans diagnosed with cancer this year will be free of the disease five years later.

But another one-half million will lose the fight, says Harvey Preisler, MD, director of the Rush Cancer Institute.

"This is why we conduct research at Rush looking for ways to improve the effectiveness of standard cancer treatments," says Preisler. "Ultimately, we want to be able to cure every patient."

Wells is one of more than 100 Rush patients battling cancer with a new strategy called biological therapy, which boosts the effects of chemotherapy and radiation. Researchers at Rush are studying two such therapies — vitamin A, a nutrient found in foods such as broccoli; and interferon, a protein manufactured by the body's cells to combat viral infections.



The treatment is based on landmark studies of cancer growth by Preisler and Rush researcher Azra Raza, MD.

When cancer strikes, Raza explains, the efficient system that controls cell division — the process by which a cell splits in two and makes a copy of itself — runs amok. Cancer cells begin to reproduce uncontrollably, spreading into surrounding tissue or, as in leukemia, throughout the bloodstream.

Studies by Raza and Preisler show that the speed with which cancer cells reproduce can influence the success of chemotherapy. Using a technique they developed to measure cancer cell growth in blood and bone marrow, the researchers discovered that slow-growing leukemias

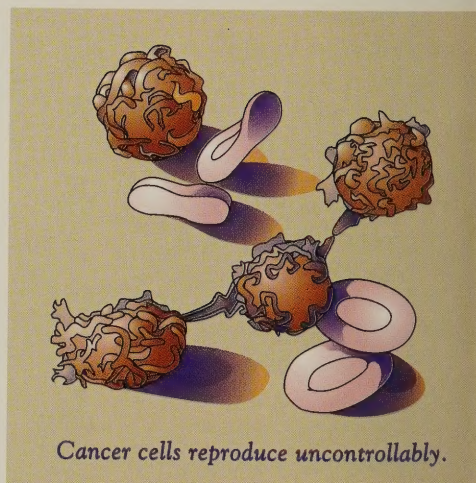
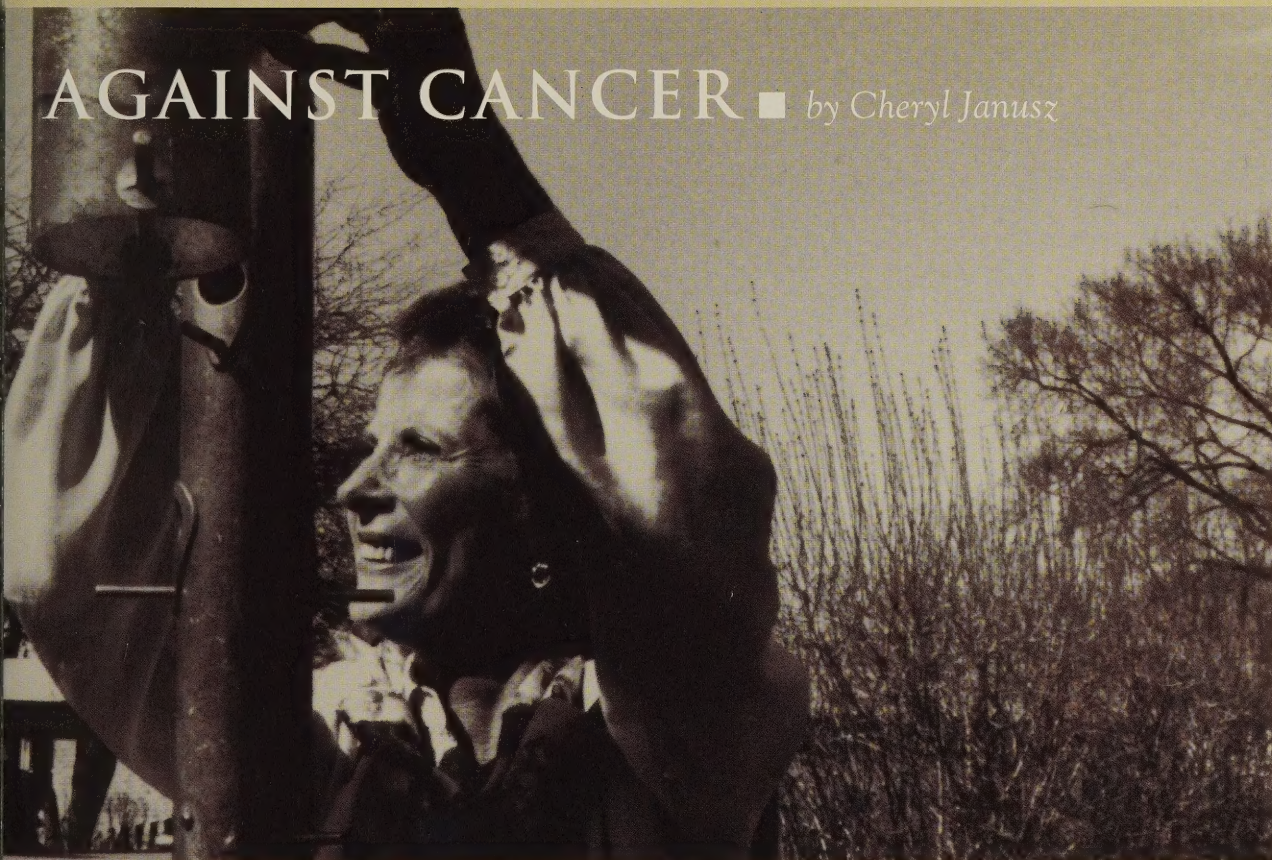


Illustration: Leslie Compere

Cancer cells reproduce uncontrollably.

STRATEGIES

AGAINST CANCER ■ *by Cheryl Janusz*



“Ultimately we want to be able to cure every patient.”

- Harvey Preisler, MD

are more effectively wiped out by multiple courses of chemotherapy than are fast-growing leukemias — like Wells’ — which tend to elude cure.

In chemotherapy, the body is assaulted with toxic chemicals that destroy cancer cells, but poison the patient in the process. This causes side effects such as fever and nausea, and leaves cancer sufferers vulnerable to life-threatening infections.

Chemotherapy is given just once every few weeks so patients can recover between courses.

“But while the body rests, the cancer doesn’t,” says Raza. “Between treatments, cancer cells that escape chemotherapy tend to keep growing. In people

with fast-growing cancers, the cells may multiply more quickly than we can destroy them.”

Results from preliminary studies show that vitamin A and interferon can slow the regrowth of cancer cells between courses of chemotherapy. A large-scale, three-year study is now under way at Rush to determine if treatment with these substances can, in turn, improve the success of chemotherapy and lead to longer cancer remissions.

Researchers suspect vitamin A and interferon affect cancer cells’ DNA, the molecule that carries our genetic master plans and controls cell division. One theory is that these substances block the faulty DNA signals that

cause cancer cells to reproduce at an uncontrolled pace.

The Rush study is entering its third year and results so far are promising, says Raza. Based on these findings, similar biological therapies are now being evaluated at Rush as treatments for chronic leukemia, head and neck cancer, and cancers of the lymphatic system, called lymphomas. Medical centers around the world have launched studies of similar biological treatments.

More than a year after her diagnosis, Wells remains cancer-free. Her physicians say this is an encouraging sign.

She will continue taking large doses of vitamin A and interferon for two more years to ward off cancer recurrence. Studies show that for every month she stays in remission, she increases her chance for complete cure.

Cancer patients are considered cured if they remain free of the disease for at least five years. "I plan to be one of the lucky ones," says Wells.

Aside from her short hair, gradually growing back after six months of chemotherapy, she bears few marks from her battle with a deadly cancer. She's back in the office full time as president of her own association management company, and continues her work as executive director of the National Bird-Feeding Society and the Wild Bird Feeding Institute.

After hours, she enjoys the simple pleasures of life with her husband, Ralph, and their three children and four grandchildren, ranging in age from 8 months to 8 years.

And this spring, she returned to her garden of perennials — peonies, daisies and other flowers that bloomed last year, even without her careful attention.

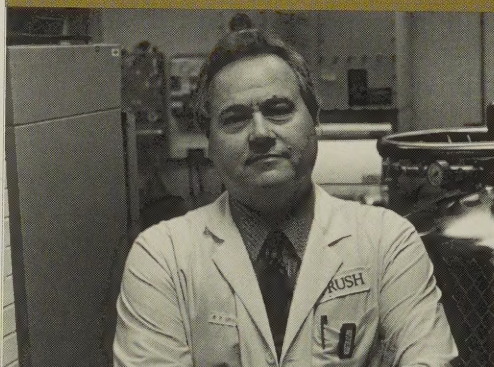
Battling a deadly illness has convinced Wells that she is as hardy as the flowers she grows.

"I won't let this disease stop me from getting on with life," says Wells.

"After all I've been through, I'm determined that this cancer is not coming back." ■

Following surgery 3½ years ago to remove a cancerous colon tumor, Rush physicians gave Eleanor Ferraro injections of her own cancer cells, irradiated so they no longer could grow. The cells were the chief ingredient in an experimental vaccine that enhanced her body's natural ability to fight the disease.

Today, the 67-year-old Midlothian woman remains free of cancer. Based on results like these, the vaccine is now the focus of a wide-scale study at Rush and 27 sites nationwide. Preliminary evidence suggests that the vaccine — given after surgery and before chemotherapy — offers some colon cancer patients the chance for longer lives or even complete cures.



Rush scientist Donald Braun, PhD

Standard treatment with surgery and chemotherapy often drives colon cancer into the period of latency known as remission.

"But in most cases, the cancer returns — often within the first few years — and at this point, patients have very poor prognoses," says Rush cancer researcher Jules Harris, MD. Harris and Rush scientist Donald Braun, PhD, are members of the national team that launched the clinical trial of the vaccine.

The vaccine, says Braun, is an immunotherapy — a treatment that heightens the immune system's ability to fight cancer.

For decades, scientists have known that the immune system is able to recognize cancer as an enemy and launch an attack. "But we now know that cancer learns to cleverly evade immune destruction," says Braun.

Cancer cells conceal themselves by blending into the crowd, shedding

the proteins that grab the immune system's attention. Braun's research at Rush shows that cancer cells also secrete chemicals that hamper the immune system's ability to wage a fight.

So by the time cancer recurs, it has an edge. Cancer cells can easily hide from the body's immune defenses — defenses that have, in turn, been weakened by the cancer and chemotherapy.

Immunotherapies like the colon cancer vaccine may help even the odds, says Braun.

The vaccine contains irradiated cells from a patient's own tumor, combined with agents that boost the body's immune defenses against cancer. The immune system is introduced to its prey and armed for the hunt.

Patients who may benefit from the vaccine are those, like Ferraro, whose cancer has spread to the tiny lymph nodes surrounding the tumor, increasing the risk for cancer recurrence. Although the tumor, lymph nodes and all visible signs of the cancer are removed during surgery, a few cancer cells could escape the knife — and germinate into full-blown cancer months, even years, later.

These patients receive chemotherapy as a preventive measure, and that's where the vaccine offers a boost. "Laboratory studies show the vaccine deploys the immune system to break up cancer cell clusters, making it easier to destroy any remaining cancer cells with chemotherapy," explains Harris.

The current study is tracking patients for five years, to see if people who receive the vaccine have a lower rate of cancer recurrence than people treated with surgery and chemotherapy alone.


Ferraro, whose mother died of colon cancer at age 45, believes the vaccine has given her priceless time with her husband, Joseph, and their children, grandchildren and new great-grandchild.

Knowing that colon cancer can run in families, she is all the more grateful for this type of research.

"Whatever they learn through studies like this will help my family," says Ferraro. "I know I'm doing what I can to protect them from this disease." ■

A Match Made on Harrison Street

■ by Sue Jeantheau



Some would say the wedding was long overdue. The longtime neighbors from Harrison Street on Chicago's west side tied the knot after a courtship that began more than 155 years ago.

Rush, the largest private hospital in Illinois, and Cook County Hospital, one of the nation's largest public hospitals, pledged to work together to strengthen their teaching, training, clinical and research programs.

The two institutions signed an affiliation agreement allowing residents — physicians in advanced specialty training — and medical students to be taught at both hospitals under one academic structure. The new relationship strengthens Rush's prowess as a teaching hospital and provides Cook County with a new corps of residents dedicated to excellence in patient care.

"With Rush's national reputation as a leader in the field of medicine and the outstanding programs Cook County has to offer, we hope to attract an even higher quality of resident to our program," says Rush president and CEO, Leo M. Henikoff, MD. "Together, we can provide a dynamic, well-rounded education that prepares physicians to handle almost any medical situation."

Rush and Cook County first met in the 1830s. After Rush Medical College received its charter in 1837, students and residents attended clinics directed by Rush faculty in the amphitheater at Cook County, which had outstanding clinical facilities not available at the college.

Nationally, physicians of the day regarded the institutions' combined training as the "Chicago School of Surgery." At County, Rush surgeons taught the likes of brothers Charles and William Mayo, founders of the Mayo Clinic in Minnesota; Alton Ochsner, the first physician to link cigarette smoking and cancer; and Roswell Park, namesake of the oldest cancer research center in the world and chief of surgery at Buffalo General Hospital for more than 30 years.

That kind of quality teaching and hands-on skill building





At the turn of the century, Rush Medical College students attended surgical clinics like this one at Cook County Hospital. Today, the relationship between the two institutions continues.

is reflected in the training opportunities available today under the new affiliation.

"Residents who know what a rich learning source County Hospital is are anxious to get into that setting," says Kathleen Shannon, MD, codirector of the Rush neurology residency program.

Since the affiliation agreement was signed last fall, more than a dozen Rush residents in general surgery and neurology have completed rotations at Cook County.

"At Cook County, you get to see patients right off the street. You have to diagnose them and schedule them for surgery. A lot of times you do the surgery and then you get to see them afterward

in clinic," says David Esposito, MD, a general surgery resident.

As a hospital dedicated to caring for patients with limited means who do not get regular medical attention, Cook County offers residents the chance to care for seriously ill patients who often come in with unusual ailments.

Second-year neurology resident Julie Rowin, MD, recalls treating patients for cysticercosis. The disease, brought on by an

infestation of worms, can cause epileptic seizures and is seen commonly in immigrants from Mexico and India who have eaten unwashed fruit from their native lands.

"I remember the first time I went to seizure clinic, I was so excited to see a patient with cysticercosis," she says. "Then my next patient had cysticercosis. I said I'd better read up on it because we never see that at Rush."

Opposites attract in this marriage, with the institutions complementing each other.

"In one city block, you've got the complete spectrum of patient care," says Esposito.

For example, Rush does not have a trauma unit, but Cook County has the nation's prototype. Rush does not have a burn unit, but its neighbor admits more than 300 burn patients yearly. Cook County does not do any transplant operations. Surgeons at Rush, the busiest surgical hospital in Illinois, perform heart, bone marrow, kidney, liver, pancreas, bone, cornea and intestinal transplants.

"Between Rush and County, I tell resident applicants that they'll see every-

thing from hemorrhoids to liver transplants," says Rush surgeon Norman Wool, MD, program coordinator for the general surgery residency.

At all stages of their training, residents learn to consider different approaches to handling patient problems and using high-tech equipment.

Says Shannon: "Residents need to be more reliant on their own clinical skills at Cook County. That's a really valuable learning experience."

The affiliation between Rush and Cook County offers a promising future to those who participate in its programs and to the people of Chicago's west side who will be served through those programs.

"The support from civic leaders for this affiliation has been outstanding,



because they recognize the potential of this relationship to improve the delivery of healthcare services to our community," says Henikoff.

Some 30 departments at Rush are talking with their counterparts at Cook County about designing new programs — from fully integrated residencies, such as general surgery, to weekly conferences on interesting or difficult patient cases. Meanwhile, Rush Medical College students have begun rotations at County, and a committee is exploring areas of common research interest and ways to coordinate joint projects.

It seems the honeymoon is just beginning. ■

THE ROAD TO FREEDOM



Illustration: Mary Flock Lempa

■ by Cheryl Janusz

At the height of his 30-year battle with alcoholism, John was drinking more than a fifth of scotch a day. "My career, my health and my marriage were falling apart," he recalls. "My life was going to the dogs, but I couldn't stop drinking."

Then in early 1994, he volunteered for a Rush study of a new treatment. In addition to weekly sessions with an addiction counselor, he took daily doses of a drug called naltrexone.

"My craving for alcohol was decreased," says John, now 59. "I could walk into a liquor store and the thought of having a drink wouldn't cross my mind."

John has been sober for more than a year and the medication that helped him is now a federally approved treatment for alcoholism. Naltrexone is the first in a wave of medications that diminish the desire to drink by shielding the brain from the effects of alcohol.

These medications offer a valuable new option for the 15 million Americans fighting alcohol addiction, says psychiatrist Michael Easton, MD, who studies treatments like naltrexone through the Rush Institute for Mental Well-Being.

"I could walk into a liquor store and the thought of having a drink wouldn't cross my mind."

"For years, alcoholism was considered a character flaw, not a disease. People were supposed to overcome it with willpower, not medication," says Easton.

Research conducted over the past 15 years, however, shows that alcohol triggers specific chemical changes in the brain — changes that cause about one out of every 10 people to get hooked.

"A drug like cocaine is so intensely habit-forming that virtually everyone who uses it is at high risk for addiction. But relatively few of the people who drink



become alcoholics," says Easton.

"This suggests there is something different about the brain of an alcoholic that makes him or her particularly vulnerable to the disease," he says.

Research suggests a family history of alcoholism should sound a warning bell. "If members of your family have other diseases — heart problems or cancer — you may be at increased risk yourself. The same holds true for alcoholism," says Rush nurse Marcella McGuire, MS, RN.

"An adolescent male with a strong family history of alcoholism has a four-time greater risk of developing a problem with alcoholism than a youth with no family history of the disease," adds McGuire, who works with Rush patients, like John, who are battling addictions.

As researchers learn more about the genetic and biological basis of addiction, healthcare professionals — and the public — are beginning to accept that alco-

holism is a chronic illness, much like heart disease, says McGuire.

As a result, the treatment of alcoholism is changing.

"Patients have more options today than ever before," says Easton. Alcoholics who are very sick may require structured inpatient care to ease the ordeal of withdrawal. Others can benefit from a range of outpatient programs such as one-on-one counseling, group therapy, or a traditional 12-step program like Alcoholics Anonymous.

And now, people may choose to supplement any one of these treatments with medication. Research suggests naltrexone, combined with counseling, helps about 50 percent of alcoholics manage their addiction. The medication interferes with alcohol's intoxicating effects in the brain by blocking the opiate receptors — neurons thought to be involved in the chemical process that drives an alcoholic to drink.

"Naltrexone decreases an alcoholic's desire to drink and changes how drinking affects the person. If an alcoholic on naltrexone does drink, it may be a lot less," says Easton.

But total abstinence is still the goal of any alcoholism treatment program.

"Medications like naltrexone aren't

magic pills that will cure alcoholism and allow an alcoholic to drink socially," Easton says. "Instead, these medications are one part of the overall management of alcoholism, much like medications are used to manage a chronic illness like heart disease."

The Rush Institute for Mental Well-Being offers various treatments to help people overcome addictions, including the combination of medication and different types of counseling to treat alcoholism. Patients may receive naltrexone or one of several other medications now under study that appear to reduce the craving for alcohol and offset the risk for relapse.

The medications themselves aren't new. Naltrexone has been used since 1984 to help recovered heroin addicts stay clean. Two of the more promising alcoholism treatments now under study at Rush—lithium and buspirone—have long been used to treat psychiatric illnesses like depression and anxiety disorder.

But used against alcoholism, these medications are proving to be effective new weapons.

"I wish I had known about naltrexone years ago," says John. "For the first time in years, I look forward to each new morning." ■

Breaking the Cycle

Naltrexone helps patients like John by satisfying the intense craving that drives them to drink. But other people turn to alcohol for reasons more complex.

Arlene, a registered nurse, took naltrexone for six months to fight a 35-year addiction. "The drug reduced my craving for alcohol, but I drank anyway," says Arlene, who is 54. "I just didn't care."

Rush staff ultimately determined that Arlene suffered from two devastating illnesses — alcoholism and depression. Studies show that more than one in four alcoholics also suffer from another psychiatric illness, often depression.

Arlene now believes she had been fighting the depression most of her life. "Alcohol was the only thing that relieved my pain," she says. "For years, drinking helped me function."

But as her depression deepened, she drank more.

"It isn't uncommon for these patients to fall into a destructive cycle in which the two illnesses feed each other," says Rush psychiatrist Michael Easton, MD. "This complicates the diagnosis and treatment."

Alcohol abuse itself can create psychiatric symptoms like depression, which worsen as the addiction progresses, Easton explains. This makes it difficult for physicians to determine whether an alcoholic has a true psychiatric illness versus a temporary problem triggered and sustained by the drinking.

"Often, the only way to discover the presence of a psychiatric illness is to get the person to stop drinking," he explains. "If the psychiatric symptoms persist when the person is abstinent, that signals the presence of another illness—one that requires a separate course of treatment in addition to the treatment for the addiction."

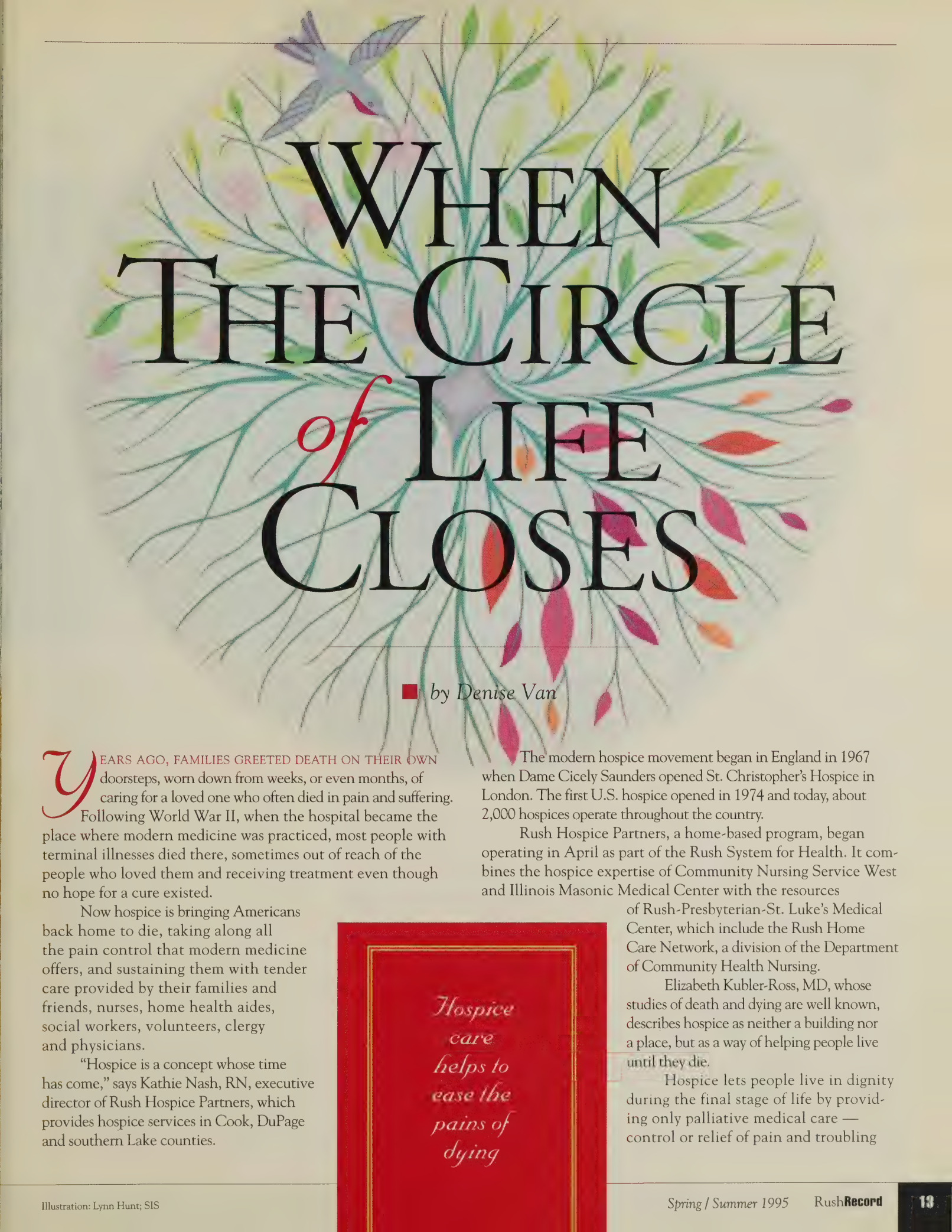
Arlene was hospitalized for a week

to get her drinking under control. Then for six months she was treated with antidepressant medications and one-on-one counseling, to address the emotional issues perpetuating her depression.

A year-and-a-half after her hospital stay, Arlene remains sober and her cloud of depression has lifted. Although she no longer takes medication, she continues to attend group therapy with other recovered alcoholics.

Arlene recently started graduate school and began volunteering at a local hospital. "This helps me feel useful, and it's a way of filling my evenings — the time I used to spend drinking," she says.

"I still have my hills and valleys—but I no longer need alcohol to cope with the lows," says Arlene. "After 35 years of hell, my life is finally on track." ■



WHEN THE CIRCLE *of* LIFE CLOSES

■ by Denise Van

YEARS AGO, FAMILIES GREETED DEATH ON THEIR OWN doorsteps, worn down from weeks, or even months, of caring for a loved one who often died in pain and suffering. Following World War II, when the hospital became the place where modern medicine was practiced, most people with terminal illnesses died there, sometimes out of reach of the people who loved them and receiving treatment even though no hope for a cure existed.

Now hospice is bringing Americans back home to die, taking along all the pain control that modern medicine offers, and sustaining them with tender care provided by their families and friends, nurses, home health aides, social workers, volunteers, clergy and physicians.

"Hospice is a concept whose time has come," says Kathie Nash, RN, executive director of Rush Hospice Partners, which provides hospice services in Cook, DuPage and southern Lake counties.

The modern hospice movement began in England in 1967 when Dame Cicely Saunders opened St. Christopher's Hospice in London. The first U.S. hospice opened in 1974 and today, about 2,000 hospices operate throughout the country.

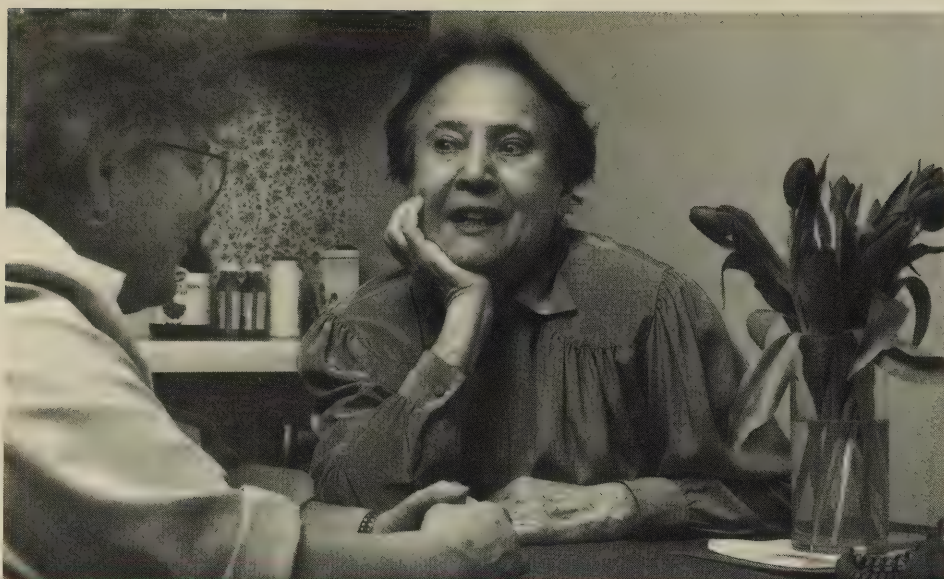
Rush Hospice Partners, a home-based program, began operating in April as part of the Rush System for Health. It combines the hospice expertise of Community Nursing Service West and Illinois Masonic Medical Center with the resources

of Rush-Presbyterian-St. Luke's Medical Center, which include the Rush Home Care Network, a division of the Department of Community Health Nursing.

Elizabeth Kubler-Ross, MD, whose studies of death and dying are well known, describes hospice as neither a building nor a place, but as a way of helping people live until they die.

Hospice lets people live in dignity during the final stage of life by providing only palliative medical care — control or relief of pain and troubling

*Hospice
care
helps to
ease the
pains of
dying*



Olga Mala (right) talks with Pat Hensley, RN, a Rush Hospice Partners nurse.

symptoms — plus social, emotional and spiritual support.

"It's the only way a patient in the final stage of life and that patient's family can get the support and care they need," says Kathryn Christiansen, DNSc, a Rush Hospice Board member and the administrator of Rush Home Care Network.

The hospice philosophy, based on compassionate care and relief of pain, appeals to many people.

Nine out of 10 of those surveyed in a 1992 Gallup Poll said they would like to spend their final days in their own homes or in the homes of family members. In a 1994 Gallup Poll 78 percent of those surveyed said people in great pain should be able to stop treatment.

Olga Mala's time for hospice came late last November. Diagnosed with colon cancer in 1991, Mala had surgery that year and again the next. She decided to forego chemotherapy and radiation, knowing that the cancer probably would return.

Her husband, Stanley, agreed with her decision. Because Mala, 77, did not want to go into a nursing home, her physician suggested hospice. "He said he knew I'd get excellent care and that it would help us financially," says Mala.

Under Medicare, hospice is a package deal. When a physician certifies that a patient's final illness probably has a six-month course to run, the patient can assign all Medicare benefits to hospice. Everything is paid for — pain-killing medicine, medical equipment, nursing care, ambulance service, social and psychological support, homemaker

services. Most insurance companies now offer policies that include hospice benefits.

"I'm ready to die, I just don't want to suffer," says Mala, echoing the words of many Americans who fear both physical and emotional pain.

"We won't let you suffer," Barbara Frei, MSW, a Rush Hospice Partners social worker, tells her.

Frei helps the Malas with their emotional pain. She visits them several times

a month, offering support, helping solve day-to-day problems as well as planning for the future and talking about death and dying.

Frei has helped the couple decide that Stanley, crippled with arthritis, will move into a subsidized senior citizen apartment building after Olga Mala dies.

"I'm so happy to know where he is going and that he will be all right. I'm really more concerned about Stanley living alone than I am about dying," Olga Mala says, twining her fingers through his.

Mala's physical pain is managed with daily doses of morphine. "It works, and when it doesn't, I'll get more," says Mala. Hospice nurse Pat Hensley, RN, who comes several times a week to the Mala's sunny second-floor Oak Park apartment, monitors Mala's pain medicine and her general health.

"Pat can read how I really feel," says Mala. "I can count on her to understand me even when I'm not saying anything. I know I must be honest with her, and she's honest with me, and when it's time, she'll tell me."

In hospice, efforts are always made to do whatever a patient wants or needs.

"We work very hard to honor the patient's choices and support the family," says Nash, who has been a hospice director for eight years. Most American hospice patients die in their homes. Because of her husband's frail health, Mala wants to die at nearby Oak Park Hospital, a Rush affiliate, and that's where she will go when Hensley tells her, "It's time."

Because hospice is the same the world over, arrangements for travel can even be made for those who are dying. Hensley tells of a patient who wanted to go to Hawaii, and go to Hawaii he did. A hospice team member met him when he arrived, and soon he was sitting on the beach, bathing his feet in the warm seas. He died a few hours later. The Hawaiian hospice team helped his family with all the arrangements for the trip to the Islands — and for the trip home.

Families sometimes are afraid of caring for their dying loved ones, but hospice provides as much support as they need.

"It's not for everybody," Christiansen admits. "Hospice requires a lot of preparation and education, and everyone has to agree that this is the end."

In most cases, hospice is only support, but if people live alone, as many AIDS patients do, or if relatives cannot help with day-to-day care, hospice helps

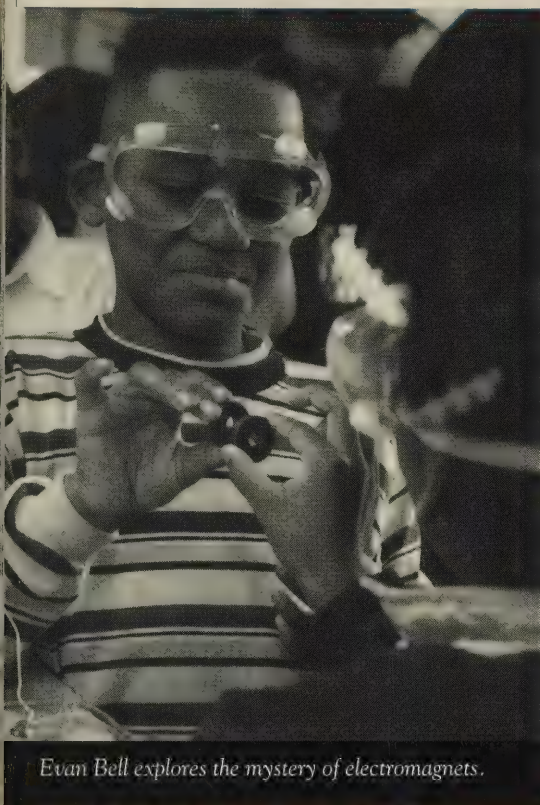
RUSH HOSPICE PARTNERS PROVIDES THESE SERVICES:

- A team that includes nurses, social workers, a physician, a chaplain, counselors and trained volunteers that coordinates the patient's care, including pain and symptom control and support services.
- 24-hour-a-day on-call services responsive to the needs of the patient and family.
- All drugs, supplies, medical equipment and specific services related to the patient's terminal illness.
- Care in an approved inpatient facility in case a hospice patient needs to be hospitalized.
- Bereavement counseling for the family before the patient's death and for up to one year following the death.

For information on hospice,
call 1-800-994-9400.

continued on page 31

Taking science on the road



Evan Bell explores the mystery of electromagnets.

Photography: Steve Gadomski

A new program of the Rush neighborhood initiative called SAME — the Westside Science and Math Excellence Network — takes hands-on science to 14 westside Chicago elementary schools that don't have science labs.

Science comes to the schools in a former Rush bloodmobile, refitted as a general science lab with running water and electricity, that can accommodate six students and a teacher at a time.

When the mobile lab went to Edward K. "Duke" Ellington School in February on one of its first runs, second graders Evan Bell and Diane Cobbs climbed in to explore the mysteries of electricity.

Under the watchful eye of teacher Yacoubi Al-Ubaidi, PhD, Bell and Cobbs connected wires to flashlight batteries, causing a miniature motor to whirl and a tiny light bulb to glow. They wrapped copper wire around a nail, connected wires to make a closed circuit and made an electromagnet that picked up metal bits. "Just like the big magnet picks up cars at a junkyard," explained their teacher.

When Bell disconnected a wire, opening the circuit, the metal dropped off the magnet.

"Now this is educational!" he beamed, opening and closing the circuit several times. The thrill of discovery showed in the second graders' eyes, protected by plastic safety glasses.

The rolling science lab has an electronic microscope topped by a tiny video camera that shows microscope slides on a TV/VCR so several students can see them at once. Other equipment includes a laptop computer, plus kits and manuals for experiments in optics, heating and cooling, and water.

Contributing to the van's renovation were four Chicago-area contractors: Gilbane Building Co.; Thorne Associates, Inc.; Chatfield Electric, Inc.; and Harry J. Kloeppel and Associates.

Rush and Chicago business and education leaders started SAME in 1992 to promote opportunities for children in westside schools to excel in math and science and encourage them to enter healthcare professions. ■

Reducing risks for diabetics

People with diabetes are at risk for coronary heart disease. Some experts suspect that the insulin diabetics inject into their skin to control the disease may contribute to this complication. But research by Rush endocrinologist John Bagdade, MD, suggests the culprit may not be the insulin but rather how the insulin enters the body.

Bagdade and researchers from Duke University and Johns Hopkins University have found that using a battery-operated pump about the size of a wallet more effectively delivers insulin to the liver and may reduce the risk of complications. The pump is implanted into the abdomen in a simple outpatient procedure.

Insulin helps the liver and other body tissues process food. Diabetics either produce no insulin at all or not enough to maintain normal metabolism. Many must take a man-made form of the hormone, usually in several daily injections.

When insulin is injected, high doses are needed to assure that ultimately the liver gets enough. But the consequence is higher than normal levels of insulin in the blood—insulin which is absorbed by surrounding body tissues.



"Too much insulin may cause tissues in the body to accumulate cholesterol. Instead of cholesterol being excreted by the liver, a protein in the blood seems to divert it to artery walls, where it builds up. This contributes to the rapidly developing coronary heart disease we see with diabetes," says Bagdade.

The pump delivers insulin directly to the liver, which filters out the excess so it won't interfere with the regular processing of cholesterol.

The pump is under review by the Food and Drug Administration and, if approved, could be available to patients in three to five years. ■

Solving the puzzle of a deadly syndrome

It's the nation's leading cause of death among infants between the ages of one month and one year, yet sudden infant death syndrome — known as SIDS — remains an enigma.

Rush researchers are now participating in a five-year nationwide study of SIDS, searching for ways to identify babies at greatest risk. The \$2 million study is funded by the National Institute of Child Health and Human Development of the National Institutes of Health.

The principal investigator at Rush, Debra E. Weese-Mayer, MD, directs the Center for SIDS Research and Disorders of Respiratory Control in Infancy and Childhood, and heads the section of pediatric pulmonary medicine at Rush. Weese-Mayer and her colleagues are known internationally for their landmark studies of breathing disorders in infants.

The nationwide study uses home monitoring to determine whether certain episodes of abnormal breathing and heart rate foreshadow SIDS. Electrodes applied to the skin track breathing,

heart rate and blood oxygen levels. If changes are detected — such as pauses in breathing or slowed heart rate — the monitor sounds an alarm.

A sensor attached to the diaper records the baby's sleeping position at the time of the event.

"Data coming out of European countries show a relationship of a prone — tummy down — sleep position to SIDS," says Weese-Mayer. "In light of this, we want to know in what positions babies are more vulnerable."

Researchers at five different U.S. sites will track more than 2,000 babies considered at risk for SIDS. This includes premature infants, siblings of infants who have died of SIDS, and infants who have suffered episodes in which they stopped breathing long enough to turn blue and experienced a change in muscle tone. They will be compared to a control group of healthy newborns who have no known risks for SIDS.

Infants are still being accepted into the study. For more information, call Sheilah Pearsall at (312) 942-2723. ■

PET scan shows body metabolism

New technology called positron emission tomography (PET) provides vivid pictures that show how well an organ, such as the brain or heart, is functioning.

"No other imaging technology does what PET can do. It can show us the metabolic function of various organ systems in action," says Amjad Ali, MD, medical director of the Rush Clinical PET center, the first such center to open in Chicago.

"We're very excited about its potential to provide unique diagnostic information and to help guide treatment decisions."

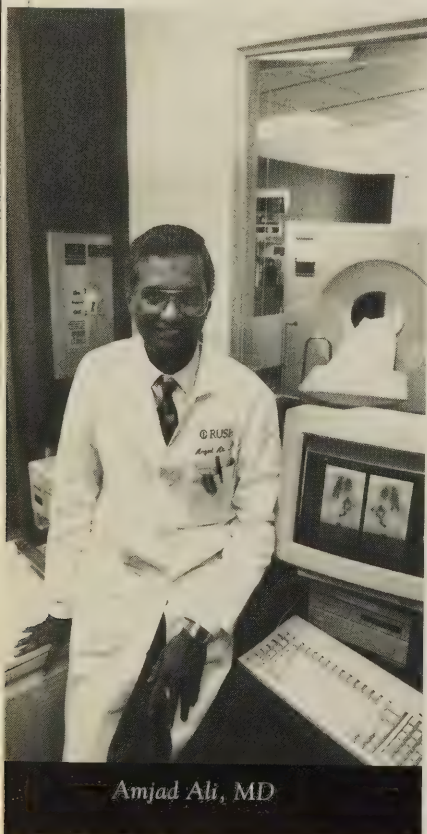
The new technology can help physicians evaluate patients with cardiac disease, neurologic disease or cancer.

The patient receives an injection of short-lived radioactive material and the scanner tracks its distribution through various parts of the body.

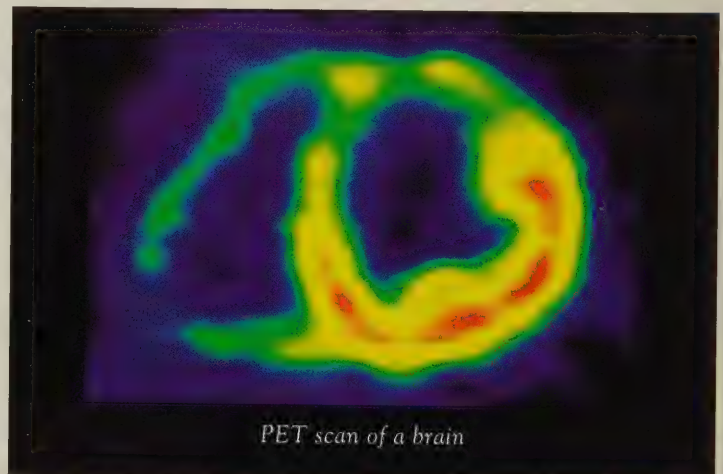
A scan can show the amount of damage the heart has suffered after an attack and helps guide physicians in deciding between bypass

surgery, angioplasty or treatment with medication.

PET can detect the extent of tumor growth throughout the body, detailing the difference between active tumors and scar tissue. It also is used in evaluating neurologic conditions, including dementia and epilepsy. ■



Amjad Ali, MD



PET scan of a brain

Miles don't matter with tele-medicine

Dennis Melody's hometown of Bristol, Ill., is about 50 miles southwest of Rush. But the distance doesn't matter with an innovation called "tele-medicine."

Three-year-old Melody, who has had two heart surgeries at Rush,

was one of the first in Chicago to receive a long-distance echocardiogram.

Melody has regular checkups with Rush pediatric cardiologist Anthony Cutilletta, MD. The physician sees him at a clinic of Copley Memorial Hospital in Aurora, a member of the Rush System for Health, just eight miles from the Melody home.



Illustration: Maggie Marek, age 6

But for Melody's most recent exam, Cutilletta stayed at Rush, where he viewed ultrasound images of blood flowing through the boy's heart as they were transmitted live from Copley.

"Patients can have an echo there and we can read it here while it's being done," says Cutilletta, director of the Rush Pediatric Cardiology Program. The images are sent over a communication system that has the power of 24 phone lines.

"This saves patients a long trip for an important but routine test," Cutilletta adds.

This pleases Melody's mother.

"My husband and I work full time. It's more convenient to run over to the clinic at Fox Valley — one less thing to worry about," says Peggy Melody. She also says that a video recording of her son's "tele-echo" was saved at Copley and a second copy, made at Rush, was saved for his files there.

"Now Copley can say that it has pediatric echocardiography service exactly the same as Rush has — because it does," says Cutilletta. ■

Halting brain damage after a stroke

A stroke injures the brain twice. First, the stroke itself interrupts blood flow to the brain, and then, the reduced or absent blood flow produces toxic substances that cause the death of brain cells.

A new medication that may limit damage caused by the second injury is the focus of a study recently begun at Rush.

Principal investigators are Jeffrey Curtin, DO, director of the Rush Neuroscience Institute's hyperacute stroke treatment program, and Maynard Cohen, MD, PhD, chairman emeritus of the department of neurological sciences, who has studied stroke for almost 50 years.

The leading cause of adult disability in the United States, stroke is the common name for what happens

when blood flow to the brain is interrupted by a clogged or burst artery.

Interruption of blood flow deprives the brain of oxygen and other important nutrients, causing death of irreplaceable brain cells, which can lead to loss of functions such as speech, memory or walking. Studies in animals have shown that the drug eliprodil interferes with the chemical process that causes brain cell death following the initial blow of a stroke.

"When the flow of oxygen-rich blood to the brain is compromised by a stroke," says Curtin, "a biochemical cascade of events creates toxic agents that cause cells to die."

The toxins invade brain cell surfaces, poisoning them, pulling them apart and allowing the cells'

components to disperse, resulting in cell death.

Eliprodil interferes with this cell-breaking process, stopping the toxin invasion of the cell surfaces. The Rush researchers are studying the drug's short- and long-term effects on patients to determine if it also limits brain damage in humans.

"By stopping the damage to brain cells, the drug may buy us time in which to treat stroke with clot buster drugs and other medications," says Curtin. Rush is the only hospital in Chicago testing the drug. ■



LOOKING AT HEALTH FROM A WOMAN'S POINT OF VIEW

■ by *Krys Kazieczko-Kuszk*

Women's health is the focus of the largest single study ever funded by the National Institutes of Health, which has chosen 40 centers around the country — including Rush — to conduct the research.

Rush and Cook County Hospital are combining efforts as a minority center in this \$625 million project called the Women's Health Initiative. The 15-year study will eventually involve 163,000 women aged 50-79.

"Right now, the information we have on women's health is just not conclusive," says Ellen Mason, MD, co-principal investigator and director of the study at Cook County Hospital.

She illustrates the dilemma with a story about a 70-year-old woman she knows, who has a bottle of estrogen tablets that she keeps near her clock radio.

"One day she looks at the tablets and thinks, 'No, it will give me breast cancer. I'm not taking this.' Another day she thinks, 'Well, they say it prevents heart attacks and keeps you from getting hip fractures, I better take one.'

"Nobody can tell her that it's really better to do this or it's really better not to do this," Mason says.

"And I find myself in that same bind when I talk to my patients."

Women's Health Initiative is designed to sift out risks and determine how diet, hormone replacement therapy and calcium and vitamin D can improve a woman's health future. An observational study will follow 100,000 of the women and track their health to determine what happens naturally as a woman ages.

Illustration: Tim Stout

The Rush/Cook County center, which will receive \$8.9 million for its part of the national study, will recruit a total of 3,620 women, at least 60 percent of them African-American.

"As little as there has been in women's health research in general, almost all of it has been in white women," says Henry Black, MD, chairman of preventive medicine at Rush and a principal investigator in the study.

"So questions about hormone replacement and dietary modification are even more important for African-American women, since we are basically starting from scratch."

Other minority centers have been designated to focus on Hispanic, Asian, and Native American Indian women, as well as African-American women.

"The goal is to provide all women, not just some, with the data they need to make good informed choices," says Mason.

Researchers are looking at the major causes of death and disability in women — heart disease, cancer and the bone-thinning disease called osteoporosis. Here are some of the questions they hope to answer:

- Does hormone replacement therapy prevent heart disease and osteoporosis?
- Does hormone replacement therapy, while it's preventing heart disease and osteoporosis, cause endometrial or breast cancer?
- Does a low-fat, high-fiber diet prevent heart disease better than, as well as, or almost as well as hormone replacement therapy, without the added risk of breast cancer and endometrial cancer? At the same time, does it also reduce breast cancer and colon cancer?
- Does calcium, which may reduce colon cancer, work just as well as hormone replacement therapy to prevent osteoporosis?

The study is enrolling participants who have already gone through menopause.

Even a woman who is in good health when she enters menopause — when her body gradually stops producing the hormone estrogen — ends up with a risk for heart disease that is even higher than it is for a man. What happens to men over a lifetime happens to women over the course of the "change." And it's not just heart disease. As women lose their estrogen protection, they're also at a substantially greater risk for osteoporosis.

Women who participate in the clinical trial will get what Mason describes as the "Cadillac package of preventive health services," including mammograms and electrocardiograms.

"We'll also find out about their quality of life, not just whether they've had a heart attack or developed colon cancer," Mason says.

"Ultimately," adds Black, "we hope to learn not only how to save lives, but also how we can reduce disability — prevent hip fractures, heart failure, coronary disease and strokes. We may not really change how long women live, but we certainly hope to make the quality of their lives much more attractive."

Women in the study incur no added expense. "We'll even help them to get here," says Michelle Hoersch, recruitment coordinator. Case managers will help women who have problems with transportation, child care arrangements and getting study medications. "Nobody is getting any experimental drugs or untested therapy," Mason emphasizes. "We are offering treatments that might ordinarily be recommended to a woman if she walked into a reputable doctor's office."

Fifty-eight-year-old Betty Grosse, of Chicago, says she signed up for the study to get some answers.

"Everyone in my family has high blood pressure and I want to find out what I can do," she says. "I want to know about menopause and getting older, too. And I want to hand something down to my daughter." ■

Much of what we now know about women's health is based on what researchers call observational studies.

A typical study, for example, takes a group of women and asks each one whether or not she is on hormone replacement therapy. Women who answered yes are then compared to those who said no. Findings in these kinds of studies have shown that women who take hormones have significantly lower rates of heart disease and osteoporosis.

"The problem in this kind of research is that there is no control for the possibility that women on hormone replacement could also be doing a dozen other things that may prevent disease," says Rush epidemiologist Lynda H. Powell, PhD, a specialist in the branch of science that deals with the incidence, distribution and control of disease.

"It could very well be that the lower risk is due to their overall healthy lifestyle rather than to a true effect of hormone replacement therapy."

"When I look at data," she adds, "I don't see any study that has gotten around this bias. It's not a problem of the study. It's a problem of study design."

Women's Health Initiative is a clinical trial, emphasizes Powell, who is a co-principal investigator in the study. Participants in this kind of research are placed into groups at random by computer, which determines whether or not they receive treatment.

"A clinical trial," says Powell, "is the most rigorous unbiased study design we have." ■

For more information about the Women's Health Initiative, call 1-800-966-3644.

All in a night's work...

Medical students take their skills to the streets

Each night, as the sun sets and the air grows colder, more than 200 men converge on a large brick building that sprawls over a dilapidated block on Chicago's near-west side.

They come from street corners, abandoned buildings, empty lots and park benches. The lucky ones come from jobs. But they all come for the same reasons — a hot meal, a shower, a warm, safe bed.

On this late February night, they come for something else, too. They know the medical students and doctors will be there, as they are once every other week, to help them with their breathing problems, chest pains, rashes, and sore feet.

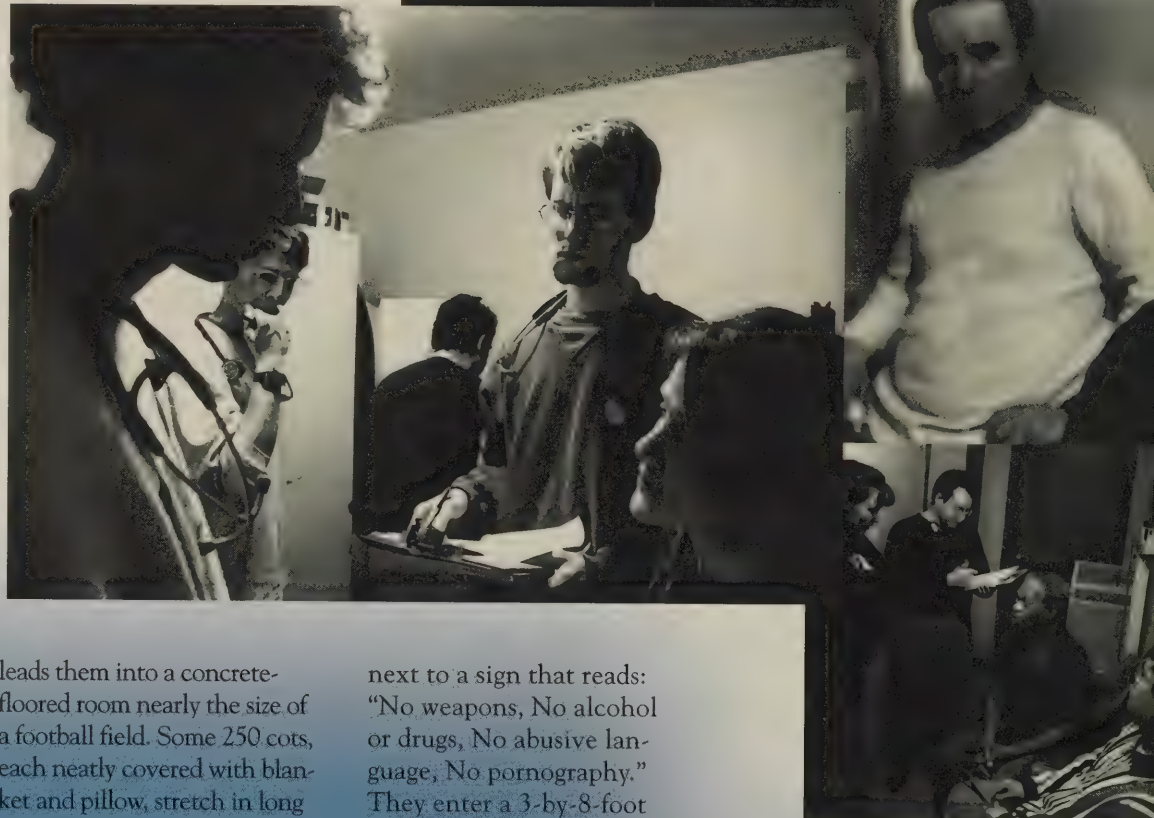
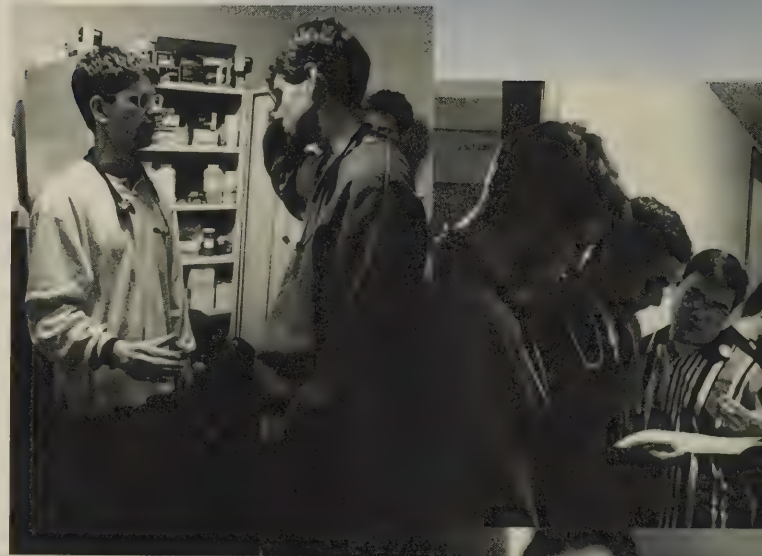
Since November 1993, volunteers in the Rush Community Service Initiatives Program have operated a free clinic inside the Franciscan House of Mary and Joseph — the largest year-round homeless shelter in Chicago. The clinic was organized by Craig Garfield, now a third-year medical student, who saw a chance for students to use their budding skills to help people who are without health insurance and often reluctant to visit doctors and hospitals.

Despite scarce resources, the tiny clinic has helped hundreds of people who otherwise might have gone untreated.

**Tuesday, Feb. 21
8:30 p.m.**

Three cars pull up in front of the shelter, located in an old mop and bucket factory on West Harrison Street. Seven medical students and a doctor weave through a crowd of men huddled outside an unmarked steel door. Some of the men are talking and laughing, some smoking, but most are quiet.

A young man sporting a goatee greets the group and



leads them into a concrete-floored room nearly the size of a football field. Some 250 cots, each neatly covered with blanket and pillow, stretch in long rows across the vast space. This is the men's dorm. A much smaller women's dorm, which sleeps 35, is next door.

The students head to the far corner and unlock a door

next to a sign that reads: "No weapons, No alcohol or drugs, No abusive language, No pornography." They enter a 3-by-8-foot hallway containing five cracked plastic chairs. Medical student Keith Monson pulls a chair into the doorway and sits down with a clipboard. The doctor is in.

8:37 p.m.

While waiting for the first patients to arrive, Valerie Barrett, MD, the attending physician for the night, and student Adam Goldin sort through a large medicine cabinet.

Getting medicine, especially antibiotics and cold remedies, has been a problem for the clinic, which relies on donations from pharmaceutical companies. The problem is likely to improve, though, with the Rush Professional Building Pharmacy recently offering to seek donations.

a week ago and his inhaler isn't helping.

Garfield asks him to demonstrate how he uses the inhaler and sees that his technique is wrong, preventing him from getting the proper dosage. The patient is clearly grateful for a quick lesson in its correct use.

"I'm not homeless, you know," he volunteers after thanking Garfield. "I just can't go home. A gang is after me."

9:02 p.m.

Student Gary Mart discusses a patient with Barrett, one of several Rush physicians who volunteer at the clinic. The patient has dangerously high blood pressure — he says he ran out of medication and his regular doctor is away.

Barrett gives the patient medication and Mart checks on him regularly throughout the evening. He is not allowed to go to bed until his pressure drops.

After examining each patient, students discuss what they've seen with the attending physician.

"The doctors do a lot of teaching during clinic," Mart says. "We discuss the patients with them and they ask us a lot of questions and help us come to a diagnosis. We're learning all the time."

9:15 p.m.

Bob Paras, a fourth-year student who has worked at the clinic since it opened, examines a patient complaining of lower abdominal pain.

Working with Paras is Ravi Nemivant, a freshman medical student spending his first evening at the clinic. First- and second-year students are matched with older students each night.

"You can really learn a lot from these guys," Nemivant

8:44 p.m.

"Somebody bit my finger in a fight," a man says as he squeezes his large frame into one of the chairs.

Garfield examines the finger and tells the man that it appears to be healing well. When Garfield asks him about his labored breathing, the man says he was diagnosed with asthma



says. "Coming here I realize how little I know."

The clinic is so popular among students that there is a constant waiting list of those who want to get involved.

Nemivant says the clinic offers him and other young students their first opportunity to practice skills they have only talked or read about. Ordinarily they wouldn't see patients until their second year of school.

"I think I need this to keep me going," Nemivant says. "Working with patients here reminds me why I'm studying medicine."

9:30 p.m.

The lights go out in the men's dorm, but the students continue working, calling patients from their beds when it is their turn at the clinic.

9:43 p.m.

A Polish man, who speaks little English, asks for a refill of some ointment as he rolls up his sleeves to expose several dime-size scabs. He is suffering from scabies, a skin infection fairly common among homeless people. Scabies is caused by mites that burrow beneath the skin and lay eggs, producing an extremely itchy rash.

Several students and Barrett examine the man. He is prescribed a scabicide and told to wash all his clothes to avoid reinfection. Since it is contagious, the shelter manager is alerted.

10:10 p.m.

Monson reports that nine patients have been treated, but 17 are still waiting. The shelter manager has asked that only a few more be seen

because most of the men are trying to sleep.

On triage duty tonight, Monson records each patient's chief complaint and decides who should have priority.

"The clinic provides us with a very different experience than we'll get in the hospital," says Monson, a first-year student. "It's a different population here, with different problems. Much of what we do here is preventive medicine."



10:23 p.m.

In the female dorm, student Lisa Newman examines a woman who is suffering from depression. She refers her to the Salvation Army Freedom Center, a non-profit health clinic operated in conjunction with Cook County Hospital. The clinic recently agreed to take referrals from the shelter.

Newman says students try to accompany patients to their referral appointments to help put them at ease and to explain their condition to the doctor.

But the next day, when Newman goes to the Freedom Center to meet her, the woman doesn't show up. Unfortunately, that's fairly common, Newman

says. Patients often fail to follow through with treatment and referrals. Recovery is hampered by their transient nature, and, in many cases, alcohol or drug abuse.

Lately, however, the clinic is seeing more repeat patients from whom students sense a growing trust.

10:55 p.m.

The last patient has been seen, and the students prepare to leave.

The final tally is in. The team, although a couple short of its usual ranks, still managed to see 14 patients.

Some men could not be seen before shelter workers asked the team to close the clinic because it was getting late.

"It was really busy tonight," Garfield says, visibly disappointed that some men had to be turned away. Most nights, he says, all those who want treatment are seen.

As the students collect their coats and backpacks, Garfield motions for them to gather around him. He thanks them for a good night's work, and offers some extra words of encouragement for the first-timers.

"One more thing," Garfield says, lowering his

voice to a whisper. "As you walk through that room, where all those men are sleeping head-to-toe, remember that they are really just like you and me — and they need the same care and attention as you and me." ■



"I think I need this to keep me going.

Working with patients here reminds me why

I'm studying medicine."

MEDICAL RESEARCH IS FINALLY QUESTIONING SOME TRADITIONAL APPROACHES TO BREAST CANCER TREATMENT. MELODY COBLEIGH, MD, WAS THE ONE WHO WOULDN'T STOP ASKING, "WHY?"

It was a fight Melody Cobleigh, MD, refused to lose.

After two years of sending proposals to the National Cancer Institute, the Rush Cancer Institute researcher and medical oncologist recently got the go-ahead to direct the country's first clinical trial on hormone replacement therapy for breast cancer survivors.

This study is just one of several research projects launched by Cobleigh, who has dedicated her career to treating and preventing breast cancer and improving patients' quality of life.

Many of Cobleigh's breast cancer patients suffer from premature menopause — hot flashes, drenching night sweats and painful intercourse — brought on by chemotherapy treatments used to destroy malignant cancer cells.

"We're taking somebody who's 30 or 40, and we're wiping out her ovarian function when nature would have done it at age 50," says Cobleigh, who directs the Rush Comprehensive Breast Center.

Estrogen replacement therapy relieves the annoying symptoms of menopause, and may also help lower a woman's risk for heart disease and osteoporosis, a bone-thinning disease. Traditionally, breast cancer survivors going through menopause are not prescribed estrogen for fear that the hormone might reactivate dormant tumor cells or cause new breast cancers.

As lead author of an article in the *Journal of the American Medical Association*, Cobleigh and her colleagues argued that hormone replacement therapy for breast cancer survivors may not be as dangerous as commonly assumed.

"The fear that exists is based on

research in a test tube, research on rats," says Cobleigh, an associate professor of medicine at Rush.

"The cure rate when you give chemotherapy to somebody with node-negative breast cancer is about 80 percent. Now we say to those same women, 'You can't have hormone replacement therapy because you had breast cancer.' Why? Because we're just afraid.

"It doesn't make sense, and women are not willing to accept answers that don't make sense anymore."

Concern for the 182,000 women diagnosed with breast cancer each year drives Cobleigh to conduct research.

After listening carefully to her patients and searching the scientific literature, she focused on premature menopause as an area that demanded further study.

"It's amazing to me that 90 percent of scientific articles on chemotherapy for breast cancer don't report incidence of premature ovarian failure.

"They report on white blood cell counts and platelet counts, but not on the toxicity, which matters most to patients."

REBEL WITH A CAUSE

■ by Barbara Harfmann

In the first clinical trial on hormone replacement therapy for breast cancer patients, Cobleigh will first study whether or not hormone replacement therapy relieves the symptoms of menopause in women taking tamoxifen. This commonly prescribed drug has been shown to reduce the risk of new breast cancers by 40 percent.

The second part of the study will evaluate cardiovascular risk factors, including blood cholesterol and bone mineral density, in 100 breast cancer survivors who have undergone premature menopause. Estrogen's effect on breast tissue also will be monitored.

"I think it's going to be safe to give cancer patients hormone replacement therapy, particularly if they're taking tamoxifen," says the 1976 Rush Medical College graduate. "Now we'll put our theories to the test."

Another pioneering project involves studying chemotherapy regimens that may carry a lower risk for premature menopause.

Cobleigh suspected a year ago that one of the most commonly prescribed

chemotherapy drugs — Adriamycin Cytosan — may be less likely than another drug — Cytosan Methotrexate 5-FU — to cause premature menopause. She recently proved it, and presented her findings at the American Society for Clinical Oncology meeting in May.

“I was flipping through pages and pages of new data from our study, and then the results that conclusively proved my theory popped out.

“I just yelped in the middle of a meeting,” she says, laughing. “I remember thinking, ‘No one in the world knows this yet. This could change the way oncologists prescribe chemotherapy, which will make patients healthier and happier.’”

Preventing breast cancer, a disease that kills 46,000 women a year, is also a top priority for Cobleigh. For the past six years, she has been studying fenretinide, a vitamin A derivative. Research shows that women who consume foods rich in vitamin A — like carrots and broccoli — are at lower risk for breast cancer.

A pilot study involved giving women with metastatic breast cancer — cancer that has spread to other parts of the body — either standard doses of tamoxifen or tamoxifen and fenretinide.

“Tamoxifen along with large doses of fenretinide seems to shrink established cancer,” says Cobleigh. “This is exciting.

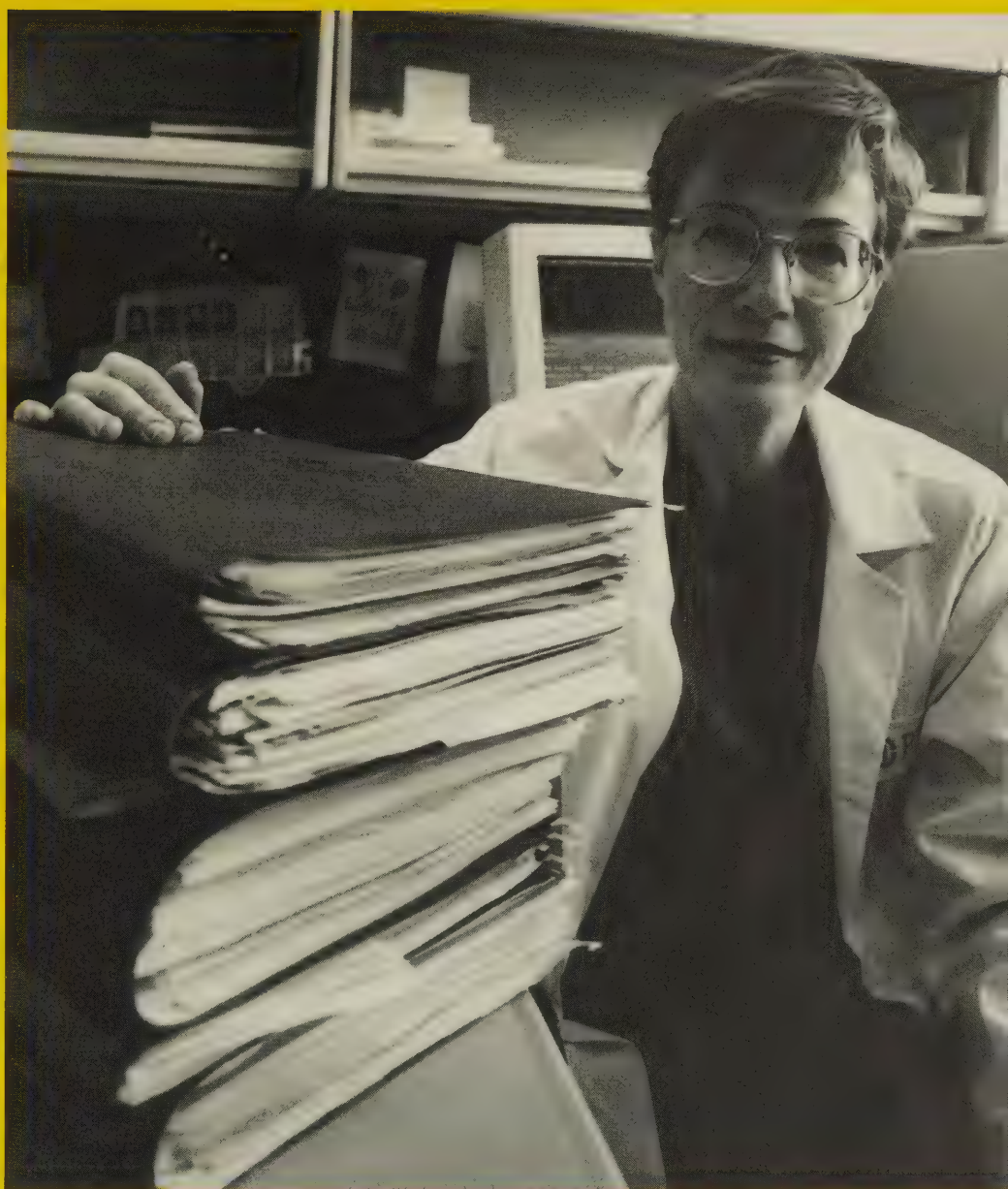
“Not only does fenretinide appear to have preventive capabilities, but it may actually be an effective therapy for combatting breast cancer.”

More research on fenretinide is under way with funding from the National Cancer Institute. As principal investigator, Cobleigh will direct a five-year national study involving 3,000 patients at 200 centers across the country.

With funding from the Jazzercise Marathon, Cobleigh and a team of surgeons, molecular biologists, biochemists, radiation oncologists and pathologists are comparing healthy and cancerous breast tissue to try to identify the changes a healthy cell goes through to become a breast cancer cell.

These cell changes, says Cobleigh, are called intermediate endpoints — signposts on the way to cancer.

The ability to identify breast cancer’s signposts would offer a screening tool to detect when a woman is at very high risk.



Determining how cell changes are affected by preventive drugs like tamoxifen and fenretinide is another goal.

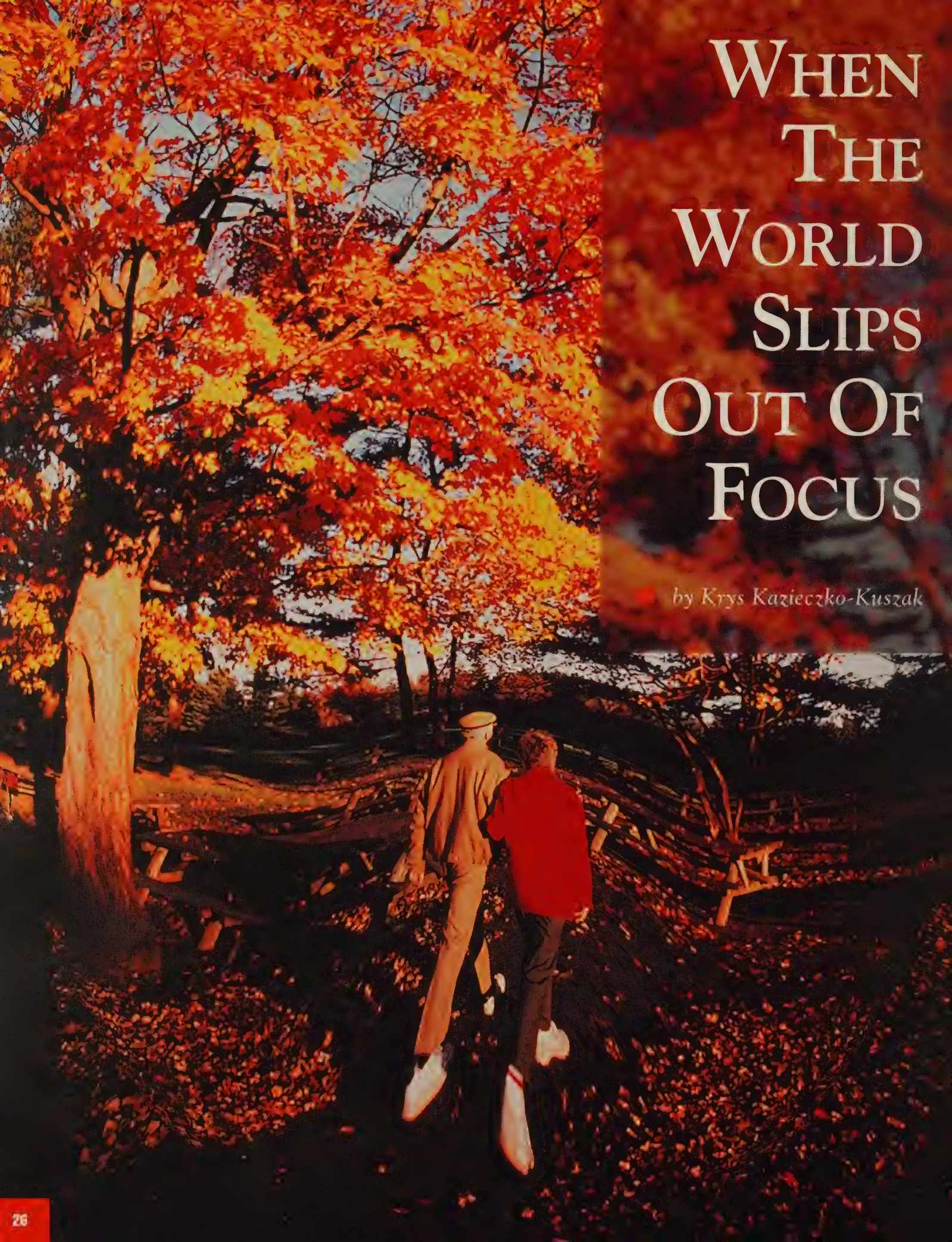
“Can we make the ‘bad’ cells revert to normal cells with vitamin A or tamoxifen?” asks Cobleigh. “This knowledge would be a major advance to finding a way to prevent breast cancer.”

Cobleigh, who wears a pink ribbon on her white hospital coat to symbolize breast cancer awareness, says research has heightened the public’s knowledge of a disease which robs society of thousands of vibrant, productive people.

“I do research because I have questions and because finding out the answers is interesting,” she says.

“ I REMEMBER THINKING, ‘NO ONE IN THE WORLD KNOWS THIS YET. THIS COULD CHANGE THE WAY ONCOLOGISTS PRESCRIBE CHEMOTHERAPY, WHICH WILL MAKE PATIENTS HEALTHIER AND HAPPIER.’ ”

“And if in the end, I can contribute toward preventing breast cancer or can cure an extra patient — that would be the real reward.”



WHEN THE WORLD SLIPS OUT OF FOCUS

by Krys Kazieczko-Kuszak

Earlier diagnosis shifts attention from caregivers to Alzheimer's patients

Irene Dressler, a retired chemist, knew she had a serious memory problem when she couldn't recall the name of her sister, Marie Louise. More than once she got lost in her own neighborhood when she took her dog for a walk. And there were times when she had to call her daughter to ask her things such as, "Where do I usually keep my iron?"

Her world was beginning to slip out of focus. As daughter Helga Bush put it, "She was at a point where everyday life was getting difficult and uncomfortable."

When Dressler, 70, was told she probably had Alzheimer's disease, the news came as no surprise.

She had read newspaper articles about this brain disease, which is more common with aging, and had already come to the realization: "Aha — that's what happens to me."

With growing public awareness, it is now more and more often that spouses, children or even the patients themselves — like Dressler — recognize Alzheimer's early signs and seek help.

"It used to be that only about a third of the patients referred to us were mildly impaired, when the problem is mainly memory," says Jacob Fox, MD, codirector of the Rush Neuroscience Institute and its Alzheimer's Disease Center.

"Now we find that as many as two out of three patients are in the mild category when we first see them."

The diagnosis is made by neurological and psychological testing, reviewing the history of symptoms, observing behavior and ruling out the possibility of other causes for the symptoms, such as strokes. Only a brain biopsy or autopsy can confirm the diagnosis, but Alzheimer's patients follow such a common pattern that specialists have little difficulty detecting it.

In later stages of this incurable disease, the focus is typically on the caregiver, who may have to deal with problems such as incontinence, wandering and aggressiveness. Eventually the person with Alzheimer's may not even remember how to talk, walk or eat.

But with earlier diagnosis there is a need to shift some attention to the Alzheimer's patient whose sense of identity is just beginning to blur around the edges.

It's a movement that's just beginning. "We're finally starting to look at this patient as a person with a problem, not a person who is a problem," says Dorothy Seman, MS, RN, clinical coordinator of the Alzheimer's Family Care Center.

In research studies and support groups, Alzheimer's patients are finally

In the beginning stages of the illness, self-esteem is one of the biggest casualties as families struggle for ways to handle the early changes.

The person with early Alzheimer's retains many abilities and a great deal of independence. The disease has not yet required that family members assume full-time roles as caregivers, so they remain, first and foremost, husband, wife, son or daughter.

"Knowing when and how to intervene requires a great deal of sensitivity and creati-



Irene Dressler likes to spend time taking care of flowers.

being asked to speak up. They seem to have a lot to say.

Rush social worker Brigid Brechling, LCSW, conducted a pilot study of 20 mildly impaired patients, interviewing them immediately after the family conference, when the diagnosis is given.

"Patients rarely ask questions at these meetings. They're surprisingly quiet," Brechling says. "So in our study we were really surprised to find how much people were willing to talk when we asked them the questions. They were amazingly open about how they coped with their illness and how it affected their daily lives."

"What we deduced from this small study is that they do maintain their personhood," Brechling adds. "Most say they are managing daily life almost as well as before....Life goes on in spite of it."

ty," says Rush social worker Dan Kuhn, LCSW.

"You don't want to draw attention to their deficits, unless they really need the help. And if you push too far, you may get an angry response."

Kuhn compares it to a waltz, when one partner skillfully takes the lead while the other, in silent agreement, follows along on the dance floor.

"Symptoms may fluctuate from day to day, even hour to hour. You have to be on your toes and know when to step in and when to step back."

For Dressler and her daughter, the dance is becoming a familiar routine.

She herself decided to give up driving last year when she became less sure of herself behind the wheel. "I want to live a little while, still," she jokes.

Daughter Bush has figured out that her mother isn't likely to initiate an activ-

"MOST SAY THEY
ARE MANAGING
DAILY LIFE ALMOST
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IN SPITE OF IT."

ity. "But when someone makes a suggestion and my mother joins in, she enjoys herself," Bush says.

Last fall, Dressler joined a support group sponsored by the Alzheimer's Association and conducted by Rush social worker June Walsh, LCSW.

For years support groups have helped caregivers cope with this illness but it has just been in the last few years that they are being formed for patients.

"These groups allow patients to share their experiences with others who understand because they are going through the same thing," says Walsh.

They may get easily distracted or lose a train of thought. Because they are

forgetful, they may be repetitive in their speech and it may be hard for them to find the right words to express their thoughts or feelings.

"But in spite of all this, they can still communicate quite effectively," Walsh says. "They're tolerant of these shortcomings and remind each other that that an illness is causing their symptoms."

Many say they don't want it generally known that they have Alzheimer's disease because they feel people will treat them differently. "The support group offers them a safe, comfortable environment where they can talk openly," Walsh adds.

While social interventions are starting to be put in place, effective medical interventions for early Alzheimer's are still lacking.

"Treatment remains a disappointment," Fox says. "We're still working on experimental drugs, but we don't have one yet that has proven to be very beneficial. One of these days we're going to hit paydirt, but I'm not convinced that we've hit paydirt yet."

In the past 10 years, much has been learned about the chemistry and the biology of the brain in Alzheimer's, but,

according to Fox, not enough to know what to do to correct the changes.

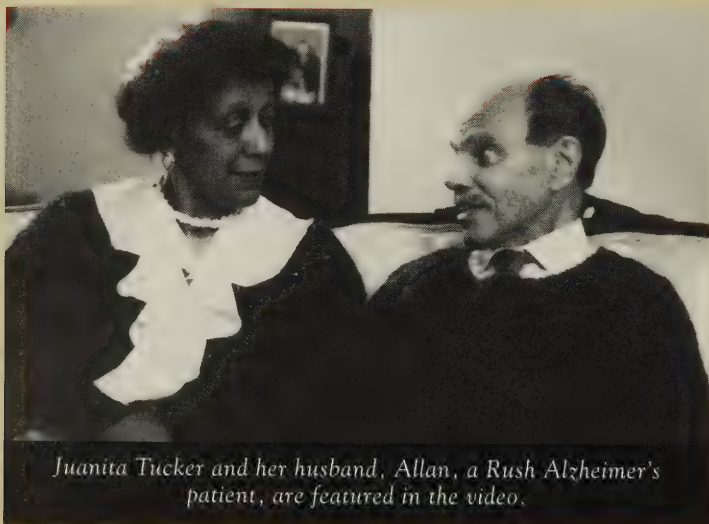
A promising study at Rush has been tracking 411 patients to get a better understanding of the natural course of the illness and a detailed picture of what changes can be expected. The project, funded by the National Institutes of Health, is headed by Denis Evans, MD, codirector of the Rush Alzheimer's Disease Center.

It will be months before researchers are ready to start publishing their findings, but one thing that is becoming increasingly clear is that there is quite a broad range of variability in this illness.

For example, at one point two patients believed to have mild Alzheimer's seem to be very similar. But over the course of time, one gets worse rapidly and the other seems to stay the same, without much decline at all.

"It could be that something is making one do better than the other. We just don't know what it is yet," says Fox. "But that's a tremendously important answer to find." ■

Intimacy and Alzheimer's



Juanita Tucker and her husband, Allan, a Rush Alzheimer's patient, are featured in the video.

Patients at the Rush Alzheimer's Disease Center and their spouses talk candidly about their feelings in the first video of its kind, "A Thousand Tomorrows: Intimacy, Sexuality and Alzheimer's."

"Alzheimer's disease affects couples in a way that changes their relationship forever," says Rush social worker Dan Kuhn, who interviewed the couples in the film.

"Because of the nature of the disease — the forgetfulness, poor judgment, personality changes, self-centeredness and inability to take part equally in decision-making — there's an imbalance that occurs in the relationship between the husband and wife," Kuhn explains.

"In most cases the spouse stops being an intimate partner and assumes the role of caregiver. The common refrain I hear is, 'I feel like I'm not widowed and I'm not married. I'm in this limbo state.'"

Produced by Terra Nova Films, the 30-minute video was created to serve as an icebreaker to encourage caregiver-spouses to talk about their feelings. The target audience is the network of support groups sponsored by the Alzheimer's Association and other organizations worldwide.

"I found that just raising the issues here among spouses we see at our center provides a great deal of relief," says Kuhn.

"To no longer enjoy marital intimacy is a very hurtful thing, but it's a very common experience in Alzheimer's disease. So let's talk about it instead of having people deal with this in isolation."

The film is available at the Learning Resource Center at Rush. Call (312) 942-6799.



Lake Forest Hospital joins Rush System for Health

Lake Forest Hospital has become the seventh affiliate hospital in the Rush System for Health.

The affiliation was announced March 1 by Leo M. Henikoff, MD, president and CEO of Rush, and William Ries, president and CEO of Lake Forest.

Lake Forest will be the sole Lake County regional healthcare

provider in the Rush System for Health, and will become a primary provider for Rush Prudential Health Plans.

"Our strategic goal for hospital affiliations is to provide access to high quality cost-effective medical services within a

30-minute drive for all patients," said Henikoff.

"Lake Forest Hospital is an ideal facility because it is recognized for scope and quality of care, and its programs provide easy access to services for all of Lake County." ■



Larry Field



Michelle Collins

Four are elected to Board of Trustees

The Medical Center's Board of Trustees has elected four new members: Larry Field, Michelle Collins, Ashley M. Maentz and Peter B. Cherry.

Field is chief executive officer of Field Container Company, L.P., the nation's largest manufacturer of folding cartons. A graduate of the University of Illinois with a bachelor's degree in business, he became president of the company in 1975 and then chief executive officer in 1990.

Collins, a partner in William Blair & Company since 1992, holds degrees from the Harvard Graduate School of Business Administration and Yale University. She was an assistant treasurer of credit audit for Chase Manhattan

Bank in New York before joining the Chicago-based investment banking firm nine years ago.

Maentz and Cherry are board members of Lake Forest Hospital, which recently joined the Rush System for Health.

Maentz is chairman of the board of Lake Forest and serves on the executive committee at Rush. She is also a member and past vice-president of the Woman's Board of Rush-Presbyterian-St. Luke's.

Cherry is chairman and president of Cherry Corporation in Waukegan, which manufactures electrical and electronic products. He received his bachelor's degree from Yale University and his MBA from Stanford University. ■



Ashley J. Maentz



Peter B. Cherry

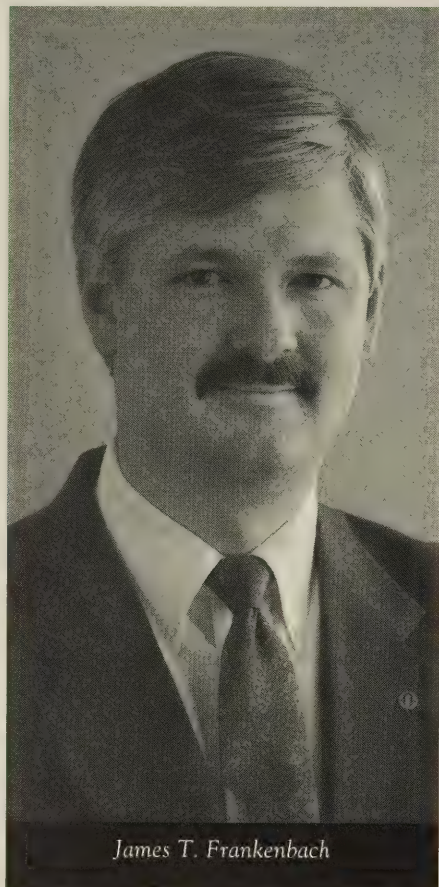
Professorship honors Abraham Chervony, MD

The Abraham M. Chervony, MD, Endowed Professorship of Medical Affairs was established in February by the Medical Center's Board of Trustees. It is the 63rd endowed chair of Rush University and the first endowed chair at Rush North Shore Medical Center.

Chervony was on the medical staff at Rush North Shore Medical Center and its predecessor, Skokie Valley Community

Hospital, for 29 years until his death early last year. An attending physician in internal medicine, he held a number of positions — department chairman, secretary and vice president of the medical staff, trustee, and the first vice president for medical affairs at Rush North Shore Medical Center.

For his long and distinguished career and the vision and dedication he brought to the Rush System for Health, he was posthumously awarded the Trustee Medal last June. ■



James T. Frankenbach

Rush announces new senior VP

James T. Frankenbach will become senior vice president for hospital affairs on July 1, succeeding Truman Esmond.

For the past four years, Frankenbach has served as president and chief executive officer of Rush North Shore Medical Center, a member of the Rush System for Health, in Skokie.

Before joining the Skokie facility in 1988, he spent 13 years at Rush-Presbyterian-St. Luke's, where he rose through the ranks to become assistant vice president for finance. He moved to Rush North Shore as vice president for finance in 1988, and two years later was named president and chief executive officer.

Frankenbach earned a bachelor's degree in accounting from Northern Illinois University and a master's in business administration from Loyola University Graduate School of Business.

At Rush North Shore, Frankenbach will be succeeded by John S. Frigo, who has been vice president of finance there since 1990. ■

Physicians and hospital form new organization

Rush physicians have joined with hospital administration to form Rush-Presbyterian-St. Luke's Health Associates. The new physician hospital organization (PHO) has more than 300 members.

The PHO will negotiate managed care contracts with insurance companies and large employers. Thomas Dent, MD, is acting CEO.

"Within the next few years, managed care will make significant inroads into the Chicago market," says Dr. Dent. "How we respond to this trend will affect both the size and the quality of our practices in the future."

The PHO provides healthcare services at a set cost, which is paid in the form of monthly fees and annual performance incentives. The PHO, not the purchaser, decides how care will be provided. ■

Navy officers on board at College of Nursing

Three U.S. Navy lieutenant commanders are on active duty in the Rush College of Nursing, serving their hitches as students in the doctor of nursing (ND) program.

Lt. Cmdrs. W. Richard Hand, Louis Heindel and Joseph Pelegri are Navy nurse anesthetists who, when they earn their degrees from Rush, will become program and clinical directors in certified nurse anesthetist academic programs at Navy hospitals in Bethesda, Md.; Portsmouth, Va., or San Diego, Calif. While at Rush, the officers also are working on doctor of nursing science (DNSc) degrees.

Heindel, who will receive his degree in August, was the first Navy nurse anesthetist posted to the Rush program.

"The Rush program is perfect for the Navy because it can be completed in two years and allows for a clinical nurse anesthesia focus at the doctoral level," he says.

Competition was tough among Navy nurse anesthetists for permission to apply for the Rush ND program, says Heindel. But Rush's entrance requirements are even tougher.

"The Rush program has a lot of prestige in the nursing and academic worlds," he explains.

The three lieutenant commanders, all of whom have taught in the Navy's own nurse anesthetist schools, are the first career Naval officers in the Rush ND program. They were sent to Rush because the Navy is seeking to upgrade the academic credentials of its nurse anesthesia faculty.

"Lou, Rick and Joe are the best and the brightest the Navy has to offer," says Margaret Faut-Callahan, DNSc, CRNA, director of the Rush nurse anesthesia program. "And they give as much to Rush as Rush gives to them. They share their educational materials and expertise with our instructors, teach in our master's program and act as mentors and role models for other graduate students." ■



U.S. Navy Lt. Cmdrs. Joseph Pelegri and Louis Heindel

Photography: Larry Dermody

Three are appointed to endowed chairs

Three appointments to endowed chairs at Rush University were announced in February.

Stuart Levin, MD, was named to the Ralph C. Brown, MD, Chair of Internal Medicine; Gordon Trenholme, MD, was appointed to the James Lowenstein Chair of Internal Medicine; and Stephanie Ann Gregory, MD, was named to the Elodia Kehm Chair of Hematology.

Levin is department chairman of medicine, vice dean of Rush Medical College and associate vice president for medical

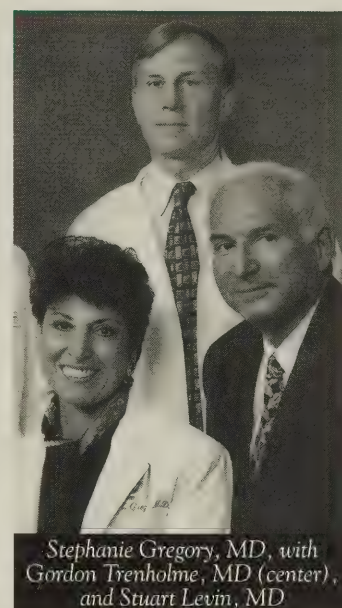
affairs. Widely recognized in the field of infectious disease, he was honored by the American College of Physicians with its Laureate Award in 1993.

Trenholme, director of the section of infectious disease, has worked closely with Levin to build that program's national reputation. He has written extensively about antimicrobial drugs, pharmacology, infectious agents and clinical syndromes.

Gregory is section director of hematology and co-director of the lymphoma center of the Rush Cancer Institute. She serves as president of the Chicago Society of Internal Medicine

and, last year, was a member of the United Nations Security Council Commission of Experts which investigated war crimes in the former Yugoslavia.

The Ralph C. Brown, MD, Chair honors the late Rush Medical College graduate and longtime member of the Presbyterian Hospital Staff. Established to promote the Rush philosophy of patient-centered care, the Lowenstein Chair honors the president of Central Steel and Wire Company. The Kehm Chair, which supports cancer research, was named for the widow of the owner of Kehm Construction. ■



Stephanie Gregory, MD, with Gordon Trenholme, MD (center), and Stuart Levin, MD

Photography: Susan Richert

Rx for the best care

A patient with a sore throat leaves the doctor with a prescription for penicillin. Another patient with the same symptoms leaves another doctor's office with a prescription for cephalosporin. Both eventually get well, but at what cost?

"Cephalosporin costs more than penicillin and is not necessarily more effective. How many patients are on some form of cephalosporin when penicillin would have been fine?"

asks Kevin Weiss, MD, of the Rush Primary Care Institute.

Weiss, director of the Institute's Center for Health Services Research, is gathering data from primary care physicians in the Rush System for Health. The information will help physicians address the effectiveness and the cost of care they deliver, and will lead to establishing standards for quality care across the Rush System.

"We eventually want to answer questions such as 'Is the care for your patients with diabetes as good as it can get?' And,

'Are you providing effective care for the least possible dollars?'" says Weiss. "These kinds of questions are the meat and potatoes of what every doctor wants to know and what every patient wants to know."

In a pilot study codirected by Rush's Department of Information Services, physicians will use personal and hand-held computers to record data about prescriptions, lab tests and consultations with other physicians in regard to certain health problems. The physicians can then use this pool of on-line informa-

tion to study their approaches to care and devise new strategies. The center's staff will be available to consult.

"We can gain insight into where certain practices are more efficient in providing care than others, learn if technology is being overused or underused and see how well preventive measures are working, such as cancer screenings and immunizations," says Weiss.

"Then we can focus on ways to change how we deliver care that will benefit all of the practices in the Rush System." ■

When the Circle of Life Closes

continued from page 14

patients establish plans for care when it is no longer safe for them to be alone.

"Every case is different," says Christiansen.

A special part of hospice is bereavement care for surviving family members for a year following the patient's death. Volunteers, many of whom have had relatives or friends in hospice, often provide this support.

"Volunteers can be a bridge for families in bereavement. When the nurses and

social workers move on to other patients, the families don't feel abandoned because they continue to talk with hospice volunteers," Nash explains.

Even though Olga Mala has made plans to die at Oak Park Hospital, she wouldn't mind being on the brown sofa in her living room when the time comes. "I hope I'll just be lying there and Stanley will come out and say, 'She's gone.'" When death comes to a hospice patient, it usually comes peacefully and quietly, says Nash.

In a scrapbook Nash keeps, there is a note from the daughter of a hospice patient.

"My mother is gone — but she left peacefully, knowing that she was loved. She had her self-respect and had gotten everything in order...I didn't view her death as terrifying...but as a very natural change. Her spirit will always be with me.... You, hospice people, will always be with me, too." ■



Charlene LeDonne

A GOOD WORKOUT for a GOOD CAUSE

■ by Anne Shaw Heinrich

Working up a sweat never felt so good for Charlene LeDonne, of Lombard, a 36-year-old mother of two who participated in the February Jazzercise Marathon.

Like more than 2,000 others who took part in 22 marathon sites throughout Illinois, Iowa and Wisconsin, LeDonne was in search of a good time and a good workout, but her main reason for joining in the effort was to support breast cancer research at Rush. More than \$235,000 was raised with this year's marathon.

"Maybe with research, we'll find out where cancer is coming from. Cancer of one kind or another is likely to affect someone you know," LeDonne says, noting her own recent battle with leukemia.

Diagnosed in 1993, LeDonne underwent 10 months of chemotherapy at Rush North Shore Medical Center in Skokie. "I kept asking my doctor, 'Why? Why does this happen to people?' Maybe in time, we'll know."

With her cancer now in remission, LeDonne says she is committed to doing what she can to support research by participating in events like the marathon.

"I just hope we find a cure for cancer," she says. "This year has really been something. I thought everything was going to stop in my life, that I was going to die. But here I am!" ■



Rush employees Denise Lynch, Lola Buckingham, Selena Armstrong and Stephanie Duborne added their support.



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C. Allen Alexander,
MD '29

TAKING A NEIGHBORLY APPROACH TO MEDICINE

By Sue Jeantheau

C. ALLEN Alexander, MD '29, got hooked on the idea of becoming a doctor after fishing in the Tennessee River. He was 12 years old when he caught a fishhook in his hand and spent an afternoon in the hospital so doctors could remove the barbed bait holder.

"I admired the doctors in their short white coats. There was something about their demeanor that I liked," says Alexander, now 94.

For 46 years, Alexander wore the white coat of a general practitioner in Kalamazoo, Mich., a hometown that has offered him a return to childhood joys like fishing and a community of caring people with whom to

share his knowledge and skill. He has the demeanor of the kind physician who helps everyone.

Part of Alexander's inspiration to become a physician came from his own family doctor, who would drive up to his childhood home in Chattanooga, Tenn., in a black horse-drawn buggy. But greater inspiration came from his mother, a maid on the "colored" ward of a local hospital, who was later trained as a nurse by hospital staff. Spurred on by her encouragement, Alexander went to college and then to medical school.

Though being an African-American in the

1920s limited his choice of schools, he applied to the top three medical schools that accepted African-American students — Rush Medical College, Harvard University and Johns Hopkins University. Accepted to all, he picked Rush.

"I decided to go to Rush Medical after I met one or two of the graduates. They said this was a more prestigious school than the others I had applied to."

Keeping up with classes, maintaining a job and getting sleep was a challenge. Waiting tables nights and weekends at a local roadhouse frequented by gangster Al Capone and his henchmen brought in good money for books, but took him away from his studies. Yet Alexander remained devoted to his education, sometimes taking

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extraordinary means to build in more study time.

"I developed a little habit of going up to the anatomy lab after hours," says Alexander. "I was not supposed to do that."

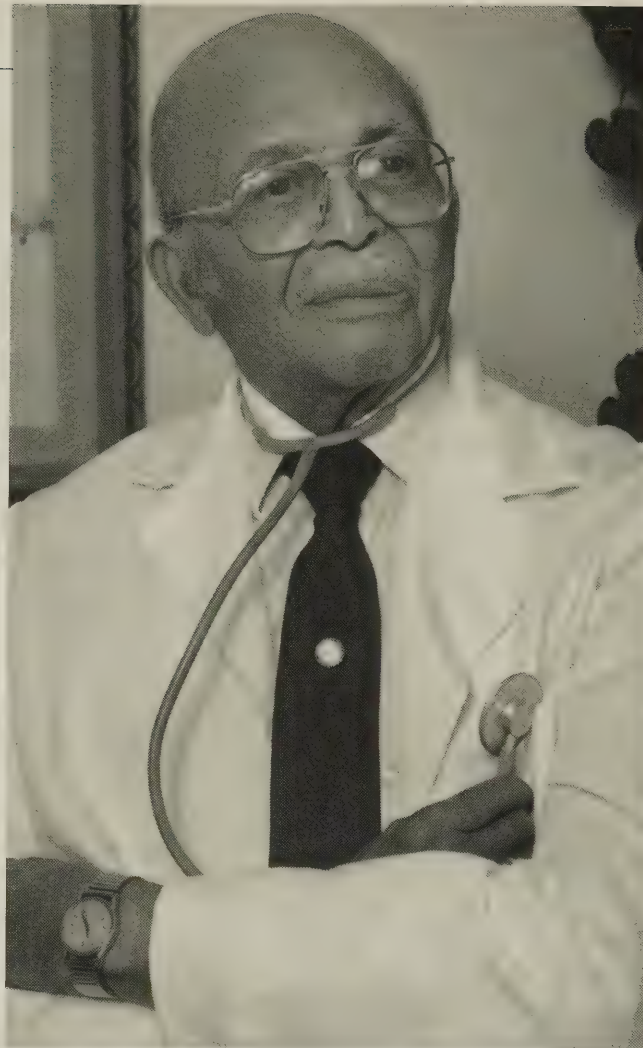
A watchman caught him after seeing lights on in the dissection room and started regularly locking the lab door. So, Alexander went undercover. The clever medical student found a new entrance to the lab through the physiology building and, gooseneck lamp and all, performed his dissections under the oil cloth that covered his cadaver.

"I got away with it," he says, laughing.

Through his medical school years, Alexander recognized the importance of having contact with patients. The class of '29, which trained at Rush's southside campus — the University of Chicago — was one of the first to make clinical rounds on Chicago's west side where students could rotate through Presbyterian Hospital or Cook County Hospital. He chose County.

"Any disease that occurred anywhere in the world you could find at Cook County Hospital," says Alexander. "There were cases of smallpox, diphtheria, scarlet fever, tonsillitis, lobar pneumonia. Of course, we had no antibiotics in those times."

In addition to his in-hospital training, Alexander made rounds in the community delivering babies in



"You became close with patients, and they considered you an advisor and a helper in all kinds of ways."



"I decided to go to Rush Medical after I met one or two of the graduates. They said this was a more prestigious school than the others I had applied to."

— C. Allen Alexander,
MD '29

homes. Before graduating, students had to perform a dozen deliveries under physician supervision and another dozen unsupervised. A nurse brought sterile bedding, equipment for cutting and tying cords, silver nitrate for babies' eyes and newspapers to protect the medical team's clothes from bedbugs in the homes.

"We usually didn't wait around too long after the delivery," he says.

The community experience served Alexander well when he started his own medical practice on the north side of Kalamazoo in 1931. Because he practiced out of his home, which was common in those days, his patients were also his neighbors. And his neighbors comprised the city's melting pot — Greeks, Italians, Poles, Croatians, Mexicans and Native Americans.

Alexander also performed surgery while on staff at Borgess Medical Center and Bronson Methodist Hospital in Kalamazoo. He served as vice president of the Kalamazoo Academy of Medicine and, in 1955, was elected a fellow of the International College of Surgery.

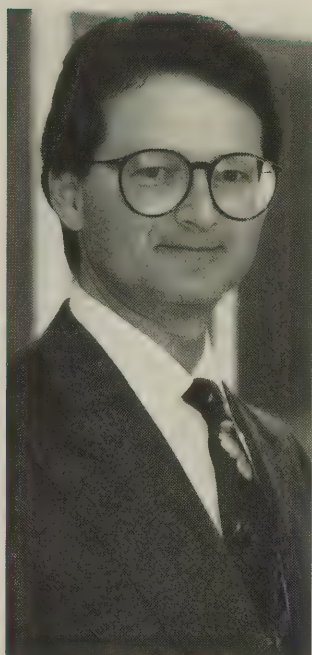
In 1977, Alexander retired from active medical practice, but he keeps in touch with former patients.

"They call just to chat and tell me they wish things were the way they were 30 or 40 years ago," he says.

continued on page 11

SPREADING THE WORD ABOUT RUSH

By Richard E. Melcher, MD '75, President, Rush Alumni Association



"People unfamiliar with Rush are amazed to learn that the Midwest has one of the most prestigious faculties in the country."

— Richard E. Melcher,
MD '75

I DERIVE a great deal of pleasure from speaking with medical students. Recently, I received a phone call from one of my former students at the Medical College of Augusta in Georgia. He was interviewing for an ob/gyn residency and had been talking with residents at programs in the northeastern part of the country.

"Amazing," he said to me. "I mentioned Chicago and all of them mentioned Rush."

GOOD REPUTATION SPREADS

Rush is becoming better known nationally in part because of the quality work of its alumni. We need to continually spread the word regarding Rush to other medical professionals because it emphasizes the quality of the institution and its students, who need our support.

A vascular surgeon in Augusta recently told me that he had commented to a nurse that it is a reasonable option to administer estrogen replacement therapy to certain patients after breast reconstruction surgery. I proudly said, "Did you know that recommendation came from a physician at Rush?" And an alumna,

no less — Melody Cobleigh, MD '76. (See profile on page 24 of the *Rush Record*.)

I'm pleased that our alums are recognized by their peers as bright practitioners and researchers, and that our students have the opportunity to meet these alumni role models through the programs of the Alumni Association.

FUTURE ROLE MODELS

It gives our students confidence to talk with Rush graduates at a Reunion Weekend or an Alumni Exchange program, where they can share experiences regarding medical and post-graduate training. Even in this small way, we can help support our students — our future alumni role models — and maintain the Rush tradition of excellence and pride in medical practice.

People unfamiliar with Rush are amazed to learn that the Midwest has one of the most prestigious faculties in the country. Our reborn school in the heart of Chicago uses the most progressive approaches to produce the finest graduates.

As a product of Rush, I'm never surprised. Are you?

ROSCETTI LECTURE PREVENTING VIOLENCE

As a resident at Cook County Hospital in 1992, John May, MD, saw gunshot victims almost daily — mostly African-American men still in their teens. Some lived to return to lives of hopelessness and more violence.

Others weren't as lucky.

Now a senior staff physician at Cermak Health Services, May provides health services for detainees at the Cook County Department of Corrections. He's also gaining attention for his efforts to conquer gun violence, a major public health threat.

At the 1995 Lori Ann Roscetti Memorial Lecture in April, May described his efforts, which include an anti-violence poster campaign.

He calls on physicians to get involved.

"We take action to prevent problems like heart disease and AIDS, but we ignore violence," said May, who believes physicians should counsel patients to avoid violent situations, just as they advise them to avoid other health risks.

NEUROLOGIST SEEKS RELIEF FOR SEIZURE PATIENTS

By Barbara Harfmann



"My patients don't just roll in from the emergency room. Most have been coping with epilepsy for years ... The vast majority can't be cured by surgery, but they're desperate to lead normal lives."

— Linda Kaplan, MD '81

A LIFELONG fascination with the brain has led Linda Kaplan, MD '81, on a quest to help epileptic patients lead normal lives.

As director of the Seizure Clinic at the University of California at Irvine, Kaplan cares for hundreds of adolescents and adults who suffer from epilepsy. Some of her patients experience hundreds of seizures a day, making it difficult for them to work, drive or even have a quiet dinner with friends.

"My patients don't just roll in from the emergency room," says Kaplan, an assistant clinical professor of neurology. "Most have been coping with epilepsy for years.

"They've been on every drug available. The vast majority can't be cured by surgery, but they're desperate to lead normal lives."

Kaplan, who completed a neurology residency at Columbia University in New York and fellowships in clinical neurophysiology and epilepsy at the Medical College of Pennsylvania, has been at the University of California since 1990.

To help her patients, Kaplan searches out and studies new anticonvulsant drugs. Under her direction,

the Seizure Clinic was one of several programs nationwide responsible for testing the safety and efficacy of the controversial drug felbamate.

Approved by the Food and Drug Administration in 1993, felbamate quells seizures as effectively as Dilantin and Tegretol, but doesn't cause the drowsiness sometimes associated with these medications.

Seventy of the 100 Irvine patients who took felbamate for 1½ years experienced dramatic improvement, says Kaplan.

"Felbamate changed people's lives," she says. "I had many patients who had never driven a car go on to earn driver's licenses because they were seizure-free for a year. One woman who hardly ever left her house got a teaching job.

"Felbamate seemed like the breakthrough drug of the 1990s."

But recently, felbamate has been linked to several cases of severe liver disease, liver failure and aplastic anemia. Sixteen out of 100,000 people taking the drug nationwide died.

Patients had to decide whether it was worth the risks to stay on felbamate.

"One patient flat-out refused to come off the

drug," says Kaplan. "He said he had too many people congratulating him and telling him, 'You're like your old self again.'"

Because of the risks, few patients now start treatment with felbamate. "Not every drug works for every patient, but we've got to keep looking for answers," says Kaplan.

As more anticonvulsant drugs are being tested, patients have more options for seizure control. Kaplan is now evaluating several promising medications, including vigabatrin and lamotrigine.

In the last decade, significant progress has been made developing drugs that more accurately target the biochemical causes of epilepsy, says Kaplan. With better medications, she is convinced that more of the country's 3½ million epileptics can lead normal, productive lives.

Kaplan delights in her patients' success stories. "I got a call at work from one of my patients who said, 'Dr. Kaplan, guess what? I bought a car.'"

"This dynamic man was almost a zombie when I met him three years ago. He got his life back."

BUILDING INTEREST IN PRIMARY CARE

By Erich E. Brueschke, MD, Dean, Rush Medical College



"Students come into medical school with a strong interest in generalist medicine. But the experiences we provide at a tertiary care hospital like Rush turn their attention to the subspecialty fields."

— Erich E. Brueschke,
MD, Dean

AT RUSH, we continually reevaluate the needs of our medical students and the community at large — and then revisit what we're doing to meet those needs.

Nationally, there is a great need for primary care physicians — a need that, in turn, means plentiful job opportunities for students entering the generalist fields. As a result, at Rush we have significantly increased our emphasis on primary care.

It is the goal of the Association of American Medical Colleges that 50 percent of today's medical students will enter the generalist fields. At Rush, we are also committed to meeting this goal.

REDESIGNING THE CURRICULUM

The truth is, students come into medical school with a strong interest in generalist medicine. But the experiences we provide at a tertiary care hospital like Rush turn their attention to the subspecialty fields.

We are redesigning our curriculum to reinforce this fundamental interest in primary care. We will expose students to the practice of generalist medicine throughout the four years of medical

school. Teaching will be increasingly problem-based, with fewer lectures and more patient contact.

For students who do pursue careers in the subspecialty fields, we will continue to offer strong training in those areas.

MEETING THE GOAL

A task force is developing a plan to implement this generalist strategy. Co-chaired by Larry Goodman, MD, associate dean of medical student programs, and William Schwer, MD, acting chairman of the Department of Family Medicine, the group will draw input and support from all areas of the Medical College, including the basic sciences. Its members will also devise ways to recruit students who have a strong interest in primary care.

This strategy will help Rush Medical College meet its national responsibilities. It will benefit Rush, too, for many of the generalist physicians we train will bring their talents home, to deliver care at the Medical Center and at our affiliates throughout the Rush System for Health.

For Trish Palmer, a fourth-year medical student at Rush, dedication to primary care has had a prestigious pay off. In October 1994, Palmer was named a Pisacano scholar, an honor that brings a \$50,000 medical school scholarship.

Palmer was chosen as an outstanding medical student who has made a commitment to enter family practice medicine. The honor recognizes her for demonstrable leadership skills, superior academic achievement, strong communication skills, character and integrity, and a noteworthy level of community service.



Rush student
Trish Palmer

SENIORS OFFER STUDENTS A LESSON IN LIFE

By Cheryl Janusz



"Working with these patients, the things we learn in anatomy and physical medicine come to life."

— Medical Student
Mike Earing



"These aren't just patients with diseases — they're people with real histories."

— Medical Student
Youngin Choi

BREATHLESS and weak from chronic heart disease, Evelyn Newsome finds it increasingly hard to get around her apartment without a wheelchair. She often sits up at night listening to hymns on the radio, too restless to sleep.

But the soft-spoken 75-year-old is clearly no complainer. Only when questioned does she talk about these problems — and add that she's concerned about a nagging cold.

"It's made me miss a few weeks of church," Newsome tells second-year medical students Youngin Choi and Mike Earing, who respond with sympathy and concern as they question her further about her daily routine.

Choi and Earing are among seven Rush students gaining a unique lesson in geriatric health care. They volunteer at the Erie Senior Health Center on Chicago's west side, conducting standardized interviews — called functional assessments — to gather information on various aspects of patients' physical and emotional well-being.

Working as a team, Choi and Earing test Newsome's vision, hearing and short-term memory, and evaluate her ability to use her arms.

They ask about her diet, social supports and home environment, including the amount of lighting in her building's stairwells and halls.

The information they gather is then passed on to Newsome's caregivers — the physicians and nurses of the Erie Senior Health Center — who offer medical care and devise solutions to any problems that are found.

Newsome, who comes to the center for weekly checkups, already receives medication and oxygen to ease her labored breathing. Based on the students' assessment, she will undergo a sleep study to determine the cause of her persistent insomnia.

Earing and Choi coordinate the Functional Assessment of the Elderly Project. It's sponsored by the Rush Community Service Initiatives Program, through which Rush medical students gain valuable hands-on experience working with seasoned professionals at clinics and other community health agencies.

The functional assessment project was launched in 1992 by Margaret Planta, now a third-year student at Rush. Earing and Choi took over the project last year.

For the volunteers, all



"The students have identified conditions like hearing loss and depression that some healthcare professionals may not recognize in a regular checkup."

— Lee Francis, MD

in their first and second years of medical school, the project is an introduction to geriatric care — a field that's currently suffering a shortage of physicians. They work under the guidance of Lee Francis, MD, a general internist at the Erie Senior Health Center and associate director of the primary care/internal medicine residency program at Cook County Hospital.

"Dr. Francis is everything we've learned a good physician should be. He has a wonderful way of talking

with his patients, of getting them to open up," says Choi.

Adds Earing, "Watching Dr. Francis in action — and then dealing with these patients myself — reassures me that the long hours of studying are worthwhile. I can use what I learn."

The Erie Senior Health Center is located on the 14th floor of the Eckhart Park apartment complex, a 350-unit Chicago Housing Authority development in the largely Hispanic, working-class neighborhood of West Town. The health center is actually three apartments that have been converted into a fully functioning clinic, complete with exam rooms and a small lab.

Here, Francis and a nine-member staff care for more than 300 patients age 59 and older, many of whom, like Newsome, live in the building.

Conditions they commonly see include hypertension, diabetes, osteoarthritis and heart disease. But problems often go deeper than physical illness, says Francis.

"Many seniors are lonely and isolated. They have no one to turn to for company or for help," he says. "Many others can't do



Erie Senior Health Center patient Evelyn Newsome (left) has her vision tested by Rush medical student Mike Earing (right), while supervisor Dr. Lee Francis and medical student Youngin Choi look on.

basic functions of daily living like dressing or getting to the bathroom."

The assessments conducted by Rush students highlight these problems, offering Francis and his staff the information they need to connect patients with the right medical and social supports — including community agencies that provide services such as meals and transportation at affordable costs.

"The students have identified conditions like hearing loss and depression that some healthcare professionals may not recognize in a

regular checkup," says Francis.

"These students have had no clinical training. They don't even know how to take a blood pressure," he says. "Yet, they've learned to do a very complex health assessment — and do it very well."

So well that in March, Earing and Choi gave a 40-minute presentation on the functional assessment project at the annual meeting of the American Society on Aging in Atlanta, Ga. They offered information on how community agencies can link up with medical schools to start similar projects.

For the students, the health center offers valuable training. "Working with these patients, the things we learn in anatomy and physical medicine come to life," says Earing.

But some lessons go beyond the classroom.

"There's a common view that all older people are sick and depressed, but that's not true," says Choi. "These aren't just patients with diseases — they're people with real histories."

Earing recalls one older man, in particular, who fascinated the students for more than an hour recounting his memories of running a speakeasy during Prohibition.

"I became involved with this project because I wanted to do a service. But it turns out that I get as much out of it as I put in," says Earing.

"The people we meet have a lifetime of knowledge," he says. "If you're willing to listen, there's a lot they can teach you."

AN UPWARD TREND AT MATCH DAY '95...

Giving new meaning to physical medicine... Dana Tarandy, who will serve his orthopedic surgery residency at the University of Illinois in Chicago, gets a boost from Frank Gentile, who will split his transitional anesthesiology residency between Tucson University in Arizona and Rush.



PRIMARY CARE ATTRACTS RECORD NUMBERS

By Cheryl Janusz

IF MEDICAL school is a four-year stress test, Match Day is a nerve-wracking final exam. On March 15 at 11 a.m., 114 tense Rush seniors gathered to find out where they'd be heading for residency training.

The relief was palpable by 11:05, as 84 percent of the Rush students learned they had matched with one of their top three choices.

And the Dean's office is pleased to report that a record 46 percent of the

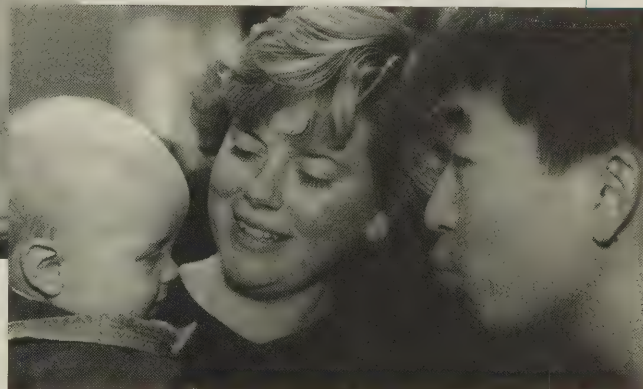
(see Dean's message, pg. 5). "We're encouraged to see these numbers increasing," says Margaret McLaughlin,

two-evening program offering information on what residencies involve — and demand.

"We wanted to give students this information early on, before they have made concrete decisions

in primary care, based on information that these fields will continue to offer good career opportunities.

But for Jeanette Edwards, who learned on Match Day that she'll be serving a pediatric residency at Loyola University Medical Center in Maywood, Ill., the decision to enter a primary care field was more basic.



MD, assistant dean of medical student programs.

Diverse factors, from a student's class rank to clinical performance, influence who gets the most

about their residencies,"

says Michael Haben, a second-year student in the Rush alternative curriculum program. Haben worked with staff from the Dean's office and Alumni Relations to coordinate the event.

Speakers included representatives from the Dean's office, residency directors from Rush and other medical centers, and recent Rush graduates who are now residents themselves.

Some students left the exchange considering careers

coveted residency spots. But few students know what the programs require until they start applying for positions in their fourth year.

In February, more than 200 first-, second- and third-year Rush students got an edge by attending the Alumni Exchange, a

"I'll study medicine and play with kids all day," she says. "What more can I ask?"

From left: Robert Paras and Lori Sostock head for residencies in family medicine.

Christopher Lipinski and wife, Melissa. Lipinski and Peter Kamhout (background) will serve residencies in emergency medicine.

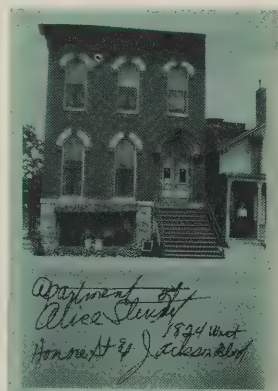
Jeanette Edwards (middle) and Vedang Londhe get tips for their pediatric residencies from Edwards' son, Patrick.

Rush students — 52 in all — will pursue training in a primary care discipline, keeping Rush in line with the national trend.

Last year, Rush Medical College inaugurated a strategy to attract more students to internal medicine, family medicine and pediatrics

ALUM'S BEQUEST HELPS FUTURE PHYSICIANS

By Jeffrey B. Meyers



The apartment of Alice Stewart, 1824 W. Jackson Blvd., Chicago 1932

MORE THAN 60 years ago, a Rush scholarship enabled the daughter of a poor West Virginia farmer to realize her dream of becoming a physician.

Today, dozens of Rush students are pursuing their own dreams, thanks to her.

Alice H. Stewart, MD, '34, died in 1992 at age 85, leaving her entire \$300,000 estate to Rush's Henry P. Russe, MD, Scholarship Fund. Stewart earned her medical degree from Rush in 1934 and practiced obstetrics and gynecology in New York for more than 50 years.

Those who knew her say they weren't surprised by the generous gift.

"Most of her education was paid for by scholarships," says Loretta Andren of New York, who knew Stewart for more than 35 years. "She

was very grateful for that, so she wanted to leave all her money to Rush to help other students in the same way."

"She was always partial to Rush because it accepted so many female medical students," recalls James Merrick, MD, who graduated from Rush with Stewart.

Stewart was born in 1907 in Frame, W.Va., a tiny rural community near Charleston. The oldest of 10 children, she worked hard at her studies and on the family farm.

Stewart earned a bachelor's degree in nutrition at Morgantown State University in West Virginia, then briefly attended the University of West Virginia School of Medicine before coming to Rush.

Friends say she was a dedicated student who worked a number of jobs

to support herself through medical school. At one point, she was a nanny for a Rush surgeon.

"She did all kinds of things while she was in school," says Andren. "Nothing came from her family, because they were very poor.

"She was very independent — a self-made woman," she says.

After graduation, Stewart moved to New York and joined a busy Manhattan practice, where she worked until retiring in 1987.

She received numerous professional honors during her life, including a doctor emeritus title from Beekman Memorial Hospital in New York and a life membership in the New York Medical Society. She was also a fellow of the

THE RUSH HERITAGE SOCIETY

Since Rush Medical College was chartered in 1837, Rush has relied on generous bequests — like that of Alice Stewart, MD '34 — to further the Medical Center's patient care, research and educational programs.

The Rush Heritage Society was created in March 1993 to acknowledge during life those who remember Rush in their estate plans. Members of the society include trustees, alumni, faculty, medical and nursing staff members, and grateful patients and their families.

Planned gifts of any size are welcome. For more information, or to inform us that you qualify for membership through a provision for Rush in your will or trust, please contact Vicki J. Woodward, executive director of the Rush Heritage Society, at (312) 942-6954.

American Society of Abdominal Surgeons and the American College of Obstetricians and Gynecologists.

In her free time, she was involved in a local boating group, called the New York Power Squadron, and the German Evangelical Lutheran Church. Stewart also enjoyed sewing and visiting friends in the country. She never married.

Stewart hadn't seen many of her former

classmates in years when she returned to Rush in 1987 for the annual Alumni Weekend celebration. There, she was honored for her earlier donations to the college.

Dozens of students will benefit from Stewart's generosity, says Larry Goodman, MD, associate dean of Rush Medical College.

"This gift will go a long way toward helping numerous students finance their educations," he said.



Alice Stewart in August 1932.

HEIDENBOEY APPROACH

continued from page 2

"My fellow practitioners call and say, 'Better be glad we quit when we did.' Medicine is not the happy, relaxing profession it once was."

Alexander calls today's U.S. healthcare system "a mess," pointing to changes in American society — a sense of indifference and a lack of humanity in personal relationships. Social changes and changes in medicine go hand in hand, he says.

Now he is documenting that opinion. In cooperation with Western Michigan University and the Kalamazoo Public Library, Alexander is completing an oral history on social changes and medical progress in Kalamazoo over the past six decades. Since 1985, he has recorded more than 150 hours of interviews with colleagues, patients and influential community leaders.

"I knew certain individuals with a meaningful story to tell which would illustrate how things were at a particular time," says Alexander. "Some of my relationships reach back 60 years. Some of the

babies I delivered are grandfathers now."

The end product of his work will be three books — one on medicine, one on social changes and the third, his autobiography. The books will be as much a testimony to Alexander's longtime care for his neighbors as archival treasures.

"You became close with patients, and they considered you an advisor and a helper in all kinds of ways," he says. "You were invited to their birthday parties and graduations. I hunted and fished with the men."

"There was a time when the family practitioner became practically one of the family. Those are the days I remember with joy."

A LOOK BACK IN RUSH HISTORY

Obstetrics Service Delivers Care to Poor

By Michael R. Bullington, MS, assistant archivist

Photos from the Central Free Dispensary of Chicago, circa 1917.

IN THE EARLY 1900s, when more than 90 percent of U.S. births occurred at home, the Federal Children's Bureau reported that childbirth caused more deaths among women of childbearing age than any disease except tuberculosis.



To tackle this problem in Chicago, in 1904, Presbyterian Hospital established an outpatient obstetrical service. The service was run in cooperation with the Central Free Dispensary, an outpatient clinic for the poor located in the Senn Memorial Building.

The mission was twofold: To care for the poor, who otherwise were delivered by midwives, often operating in unsanitary conditions, and to provide obstetrical training for Rush Medical College students. Standards were beginning to be established for medical schools, including a student's attendance at a minimum

number of births. Rush was one of the first schools in the U.S. to provide training in obstetrics, which was just starting to earn respect as a medical specialty.

Guidelines for the service outlined the staff duties: "This staff shall consist of



physician, nurse, and student of the graduating class. ... The physicians, under the direction of the department, shall be in charge with the student and nurse as assistants. Visits during the puerperium are to be made by the nurse for the first three days, and by the student for ten days, or until the patient shall be discharged by the Department."

In 1910, the *Presbyterian Hospital Bulletin* reported on the service.

"... this service has grown until today it reaches out into all parts of the city and cares for about one hundred and twenty-five cases yearly.

"Internes (sic) and nurses go to the homes of the

patients with a well-equipped outfit suitable for conducting the confinement according to the best hospital techniques, bringing to these poor and often ignorant mothers the visible expression of cleanliness and asepsis. ...

"It is only by a practical



application of the most modern scientific cleanliness that obstetrics is robbed of its past terrors, child-bed fever for the mother ... and blindness for the child."

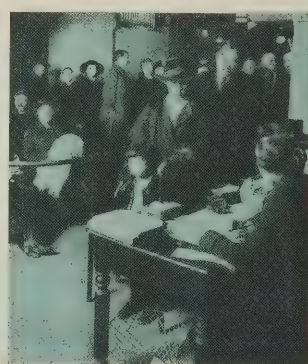
Documents show that by 1931, Rush had further developed its obstetrical clinical curriculum.

"The students are to see at least 12 cases, 6 as a junior and 6 as a senior ... the students will be divided into groups, each group comprising 10 Seniors and 10 Juniors."

Instructions in the book-

let for home deliveries are detailed, down to what to do with each cotton ball carried in the "grip" or doctor's bag obtained from the hospital.

"Upon receiving a call, the student will come to the hospital quickly and after receiving address and grips,



go out to the home. The Junior is to be the assistant to the Senior, the Senior being under the direct supervision of the internes (sic) or nurse in charge. The latter are to be responsible to the attending man."

By 1936, the *Bulletin* reported on its new portable incubator that could safely bring sick or premature babies who had been delivered at home to the hospital, and boasted that 905 mothers had been delivered by the outpatient service in 1935.

By 1942, when the service was disbanded, 75 percent of births in urban areas took place in hospitals.

CLASS NOTES

1930s

NATHANIEL E. REICH, MD '32, of Brooklyn, N.Y., has retired after 60 years of practicing and teaching cardiology. He has written three medical textbooks, 53 research papers, a nonmedical book and a collection of poetry, *Reflections*. He has also exhibited his artwork in 13 shows and at four museums.

NOAH BARYSH, MD '33, and his wife, Gertrude, have permanently moved to Palm City, Fla.

WILLIAM L. CURTIS, MD '35, is a retired radiologist, living in Mercer Island, Wash. He just completed his memoirs.

BERNADINE SIEBERS-DeVALOIS, MD '35, enjoys living near her family — which includes five great-grandchildren — in Colorado Springs, Colo. "My pacemaker, energized with a new battery, and strong Christian faith keep me going fairly strong at age 86," she says.

H. SIDNEY HEERSMA, MD '35, of Kalamazoo, Mich., continues to hold a clinic for children with learning and attention deficit disorders, and to teach pediatric residents through Michigan State University in Kalamazoo. He also runs activities at a neighborhood community center.

MAURICE SCHNEIDER, MD '35, and his wife, Rea Schneider, MD, are retired and living in Los Angeles, Calif., near their children and grandchild, Joseph. "Rea volunteers teaching at a pulmonary clinic. I do nothing," he quips.

VERRILL J. FISCHER, MD '37, keeps busy teaching family medicine residents in his home of Minot, N.D. He has two sons who are MDs, one a radiologist, the other a urologist. "Still can't read fiction. Read medical journals," he says.

ALAN A. LIEBERMAN, MD '37, of Elgin, Ill., is proud to announce that his grandson is a third-year medical student at the University of Washington, on his way to becoming the fourth MD in the family.

1940s

LEIBERT J. SANDARS, MD '41, of Reno, Nev., has retired from his radiology practice and is now actively engaged in water color and oil painting. When time permits, he golfs.

ANDREW K. BUTLER, MD '42, has retired as chief of the department of radiology at Ohio Valley Medical Center in Wheeling, W.Va., after 32 years.

1970s

FRANK C. MADDA, MD '74, is chairman of the department of surgery at Good Samaritan Hospital in Downers Grove, Ill., and was elected president of the Chicago Society of Plastic Surgeons for 1994-95.

LAWRENCE F. LAYFER, MD '74, was recently appointed vice president of medical affairs at Rush North Shore Medical Center in Skokie, Ill., where he has been a medical staff member since 1981.

NEIL S. CALMAN, MD '75, a family physician practicing in the Bronx, was awarded the 1994 American Academy of Family Physicians Public Health Award for his efforts to bring high-quality medical care to disadvantaged urban communities.

RICHARD F. FRIRES, MD '77, is currently the chief of staff and chairman of the department of emergency medicine at Meridia Huron Hospital in Cleveland, Ohio. His wife, Charlotte, is a practicing nurse midwife.

DAVID GRAY, MD '77, of Corpus Christi, Texas, continues to work out of a county trauma center, but he says it's getting old. "I'm morphing into occupational medicine in my own clinic," reports David. He and his wife have two small children and are expecting a third.

STEVEN A. GILES, MD '79, is a partner in a new family practice group in Waukesha, Wisc., and is involved in the development of an arts medicine fellowship at Interlochen Center for Arts in Michigan. Active in sports medicine, Steven will be part of the medical support group for the 1996 Olympic Games in Atlanta, Ga.

THOMAS A. DEUTSCH, MD '79, an associate professor of ophthalmology at Rush Medical College, was awarded the Mark H. Lepper, MD, Society Award for Excellence in Teaching at Rush in January. The Mark Lepper Society is a group of teachers dedicated to high standards in their field. Dr. Lepper was a distinguished epidemiologist and the first dean of the reactivated Rush Medical College.

1980s

NEAL EPSTEIN, MD '80, is co-director of the Inherited Cardiac Diseases Section at the National Institutes of Health.

CLASS NOTES

1980s *continued*

RANDY J. EPSTEIN, MD '80, is an ophthalmologist, specializing in cornea-external disease and refractive surgery, with offices at Rush, in Highland Park, Ill., and at the Illinois Cornea Center in Hoffman Estates. He was recognized for his service to the American Academy of Ophthalmology with an Honor Award at its 1994 meeting.

CAROL KROHM, MD '80, MPH, has been named a diplomate of the American Board of Quality Assurance and Utilization Review Physicians. She is associate medical director of HMO Illinois, a Blue Cross/Blue Shield affiliate.

FRED M. VOLKMAN, MD '81, is advancing in his career as a physician-executive. He is the vice-president for plan operations and medical director of FHP/Great Lakes in Illinois.

NEIL E. WINSTON, MD '81, is an emergency physician at EHS/Trinity Hospital in Chicago.

CYNTHIA A. HAHN, MD '83, is a neurosurgeon, subspecializing in pediatric neurosurgery, in private practice in Spokane, Wash. "I enjoy the mountains, lakes and outdoors of the Pacific Northwest," she says.

GEORGE MAROSAN, MD '83, is a military plastic surgeon at Madigan AMC in Tacoma, Wash., where he likes the university-style, broad-based practice. Having passed his plastic surgery boards, he's enjoying life and spending more time with his wife, Boglarka, and 2-year-old son, Zoltan.

DAVID A. LADDEN, MD '84, is a cardiothoracic surgeon and, along with his wife, Judy, a parent to Sara Hadley, born July 27, 1994. "Justin, 10, and Matthew, 8, are the best big brothers," he says. "Send diapers!"

NINA A. PALEOLOGOS, MD '85, practices neurology and neuro-oncology at Evanston Hospital in Evanston, Ill., and is an assistant professor of neurology at Northwestern Medical School in Chicago. She's been happily married to Mel Wichter, MD, for four years.

CHRISTOPHER DeWALD, MD '87, is an orthopedic surgeon with offices at Rush and at Holy Family Medical Center in Des Plaines, Ill.

KATHRYN A. LEMMERMAN, MD '87, is a family practice physician in Falls Church, Va., who combines conventional medicine with alternative practices like acupuncture. She invites any classmates visiting the area to stop by.

BRIAN LOCKER, MD '87, moved back to Mississippi with his wife, Elaine, and children — Sara, 6, and Philip, 3 — to be an attending ob/gyn at Keesler Medical Center. He has signed a contract with Rockford Memorial Hospital in Mississippi and will start there in July.

MICHAEL EDWARD CUCKA, MD '88, is enjoying his second year of orthopedics private practice in Connecticut. He and his wife are expecting their third child, a girl.

DEAN A. DELMASTRO, MD '88, is in the fourth year of a hematology/medical oncology fellowship at the University of North Carolina in Chapel Hill and, after July 1995, will be looking for a permanent position.

SUZANNE LaFOLLETTE, MD '88, is a hematologist/oncologist with the Rush Cancer Institute, and is on the medical staff of Holy Family Medical Center in Des Plaines, Ill.

1990s

MICHAEL HEJNA, MD '90, PhD, is an orthopedic surgeon, living in Riverside, Ill. He and his wife, Michelle, welcomed 7 lb., 2 oz. Amanda Rose on July 29, 1994.

JEFFREY MARK SMITH, MD '90, completes his orthopedic surgery residency at the University of Tennessee in July 1995, and then moves on to a fellowship in joint reconstruction surgery and trauma at the Sunnybrook Health Science Centre in Toronto, Canada. He and his wife, Shannon, became the proud parents of Ryan Alexander in July 1993.

IN MEMORIAM

1920s

PAUL H. VAN VERST, MD '24, of Holland, Mich., Dec. 28, 1993.

GEORGE B. CALLAHAN, MD '26, of Waukegan, Ill., Jan. 18, 1995.

DANIEL TRUETT GANDY, MD '28, of Austin, Texas, April 26, 1994, age 94.

JOSEPH OSCAR JONES, MD '28, of Murray, Utah, May 18, 1994, age 94.

1930s

WEASE LEE ASHWORTH, MD '30, of Buckhannon, W.Va., March 27, 1994, age 89.

EDWIN J. DECOSTA, MD '30, of Chicago, Jan. 26, 1995, age 88.

IRENE NEUHAUSER, MD '30, of Chicago, May 1, 1994, age 95.

JACK H. SLOAN, MD '31, of Chicago, Jan. 10, 1994, age 90.

CATHARINE E. LOGAN, MD '33, of Monticello, Ind., Nov. 25, 1994, age 93.

JOHN A. CREMER, MD '34, of Grand Rapids, Mich., Feb. 28, 1994, age 87.

ORAM C. WOOLPERT, MD '34, PhD, of Columbus, Ohio, Oct. 21, 1994, age 96.

FREDERICK H. DOBBS, MD '35, of Charleston, W.Va., March 1994.

WALTER SIGMUND POLACHECK, MD '36, of Milwaukee, Wisc., May 3, 1994.

JACOB S. ARONOFF, MD '37, of New York City, Feb. 19, 1994, age 80.

PAUL ASHLEY, MD '37, of Chicago Heights, Ill., in January 1995, age 84.

RUTH BERNICE BALKIN, MD '37, of Highland Park, Ill., April 9, 1994, age 81.

SAMUEL ELVIN PENN, MD '37, of Pittsburgh, Pa., in April 1994.

GRAHAM CAMERON, MD '39, of N. Fort Myers, Fla., Nov. 2, 1994, age 84.

PHILIP KRAMER, MD '39, of Natick, Mass., November 1994.

1940s

WILLIAM T. BRANNON, MD '40, of Montgomery, Ala., in May 1994.

WILLIAM H. TODD, MD '41, of Tacoma, Wash., Sept. 7, 1994.

JOHN GILL MORRISON, MD '42, of Piedmont, Calif., Nov. 26, 1994, age 80.

W. KENNEDY DR. RUTH SCHMIDT

Dr. Gilchrist, professor emeritus at Rush Medical College, died November 13, 1994, at age 90.

A member of the Rush Medical College Board of Trustees, Dr. Gilchrist was instrumental in the college's merger with Presbyterian-St. Luke's Hospital in 1969 and its reactivation in 1971.

Dr. Gilchrist was a noted gastrointestinal and cancer surgeon who wrote more than 70 articles and provided seminal information on how colon cancer spreads and new surgical techniques. A leader in

the American College of Surgeons, he served for many years as one of its chief officers.

"He always had compassion and empathy for his patients and his fellow workers," said Ruth Schmidt, RN (Pres. '34), former director of OR nursing at Rush, who worked with Dr. Gilchrist for more than 30 years.

"He epitomized what a good doctor should be," said Miss Schmidt.

Survivors include a son, Dr. Kennedy; a daughter, Lynn Rheinheimer; a sister, Anita Houston; and three grandchildren.

MANUEL STILLERMAN, MD

Dr. Stillerman, an internationally known ophthalmologist on staff at Michael Reese Hospital in Chicago, died September 25, 1994, at age 78.

Dr. Stillerman was a general ophthalmologist who specialized in pediatric neuro-ophthalmology. He published numerous scientific articles.

From 1961 to 1985, he was chairman of the ophthalmology department at Michael Reese Hospital and he headed the institution's ophthalmology residency program.

Dr. Stillerman was also an accomplished violinist. To earn money for his medical education, he played and sang with the Lou Diamond Orchestra in the Empire Room at Chicago's Palmer House.

"Manny was a man of wide interests," said Frederic A. de Peyster, MD '40. "As a physician, he had a keen perception for diseases and knowing how to treat them. Just as important, he had compassion and integrity."

Dr. Stillerman is survived by his wife, Arlene; two daughters, Susan Aaron and Sidney Royer; a son, Dr. Charles; a brother, Irving; and five grandchildren.

EDITOR

Rush MD is published twice a year by the Alumni Association of Rush Medical College, and produced by the Office of Alumni Relations, Department of Philanthropy, Marketing and Public Relations, at Rush-Presbyterian-St. Luke's Medical Center: 1700 W. Van Buren, Ste. 250, Chicago, IL 60612, (312) 942-7165.

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RUSH

ALUMNI CALENDAR

DEPARTMENT OF PSYCHIATRY GRAND ROUNDS

Sponsor: Department of Psychiatry. Every Wednesday (except first Wednesday of the month), 10:30-11:30 a.m., September-June, A.B. Dick Auditorium. *For more details, contact Lenore Opasinski, (312) 942-5372.*

SLEEP CENTER GRAND ROUNDS

Sponsor: Department of Psychology and Social Sciences. Every Thursday, 9:30-10:30 a.m., Sleep Center Conference Room, 218 Rawson. *For more details, contact Rosalind Cartwright, PhD, (312) 942-5440.*

PREVENTIVE MEDICINE GRAND ROUNDS

Sponsor: Department of Preventive Medicine. Every Tuesday at noon, September-June, Claude H. Searle, MD, Conference Center. *For more details, contact Sherry Nelson-Mitchell, (312) 942-2337.*

JUNE 8-10, 1995

RUSH MEDICAL COLLEGE ALUMNI WEEKEND '95

Special reunion activities for the classes of 1935, 1940, 1975, 1980, 1985 and 1990.

JUNE 8, 1995

- Executive Council Meeting
- Social Hour for Returning Alumni
- Benjamin Rush Society Annual Dinner Meeting

JUNE 9, 1995

- Alumni Day (on campus)
- Commencement Banquet Hotel InterContinental, Chicago

JUNE 10, 1995

- Anita Dee II Luncheon Cruise, Navy Pier, Chicago
- Commencement Exercises for Rush University

JUNE 17, 1995

The Eighth Annual Frederic A. de Peyster, MD, Rush Alumnus Lecture. *For details, contact Eileen Pehanick, (312) 942-6519.*

OCTOBER 31, 1995

Rush Ophthalmology Alumni Reception, 6-8 p.m., Atlanta, Ga. *For details, contact William E. Deutsch, MD, (312) 942-2734.*

DECEMBER 6-8, 1995

Neurology for the Non-Neurologist Conference. Sponsor: Department of Neurological Sciences. Various speakers. Swissotel, 323 E. Wacker Dr., Chicago. *For details, contact Vickie O'Sullivan, (312) 942-7119.*



Rush Record

Fall/Winter 1995

A Publication of Rush-Presbyterian-St. Luke's Medical Center



STROKE

About the Cover:

After a stroke in 1985, Sylvia Fulton toned down her stressful lifestyle and started taking medication to prevent further strokes. Today, Fulton is a healthy, independent 75-year-old.

Photo: Jean Clough

Photo manipulation: Kurtzman Slavin Communications

RushRecord

Fall/Winter 1995

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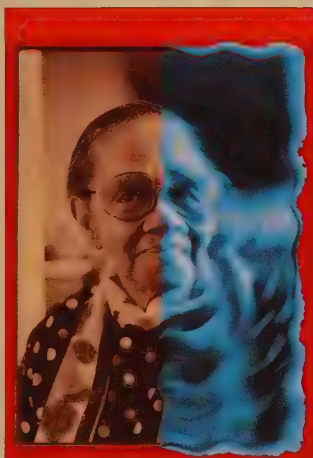
A Member of the Rush System for Health

 RUSH

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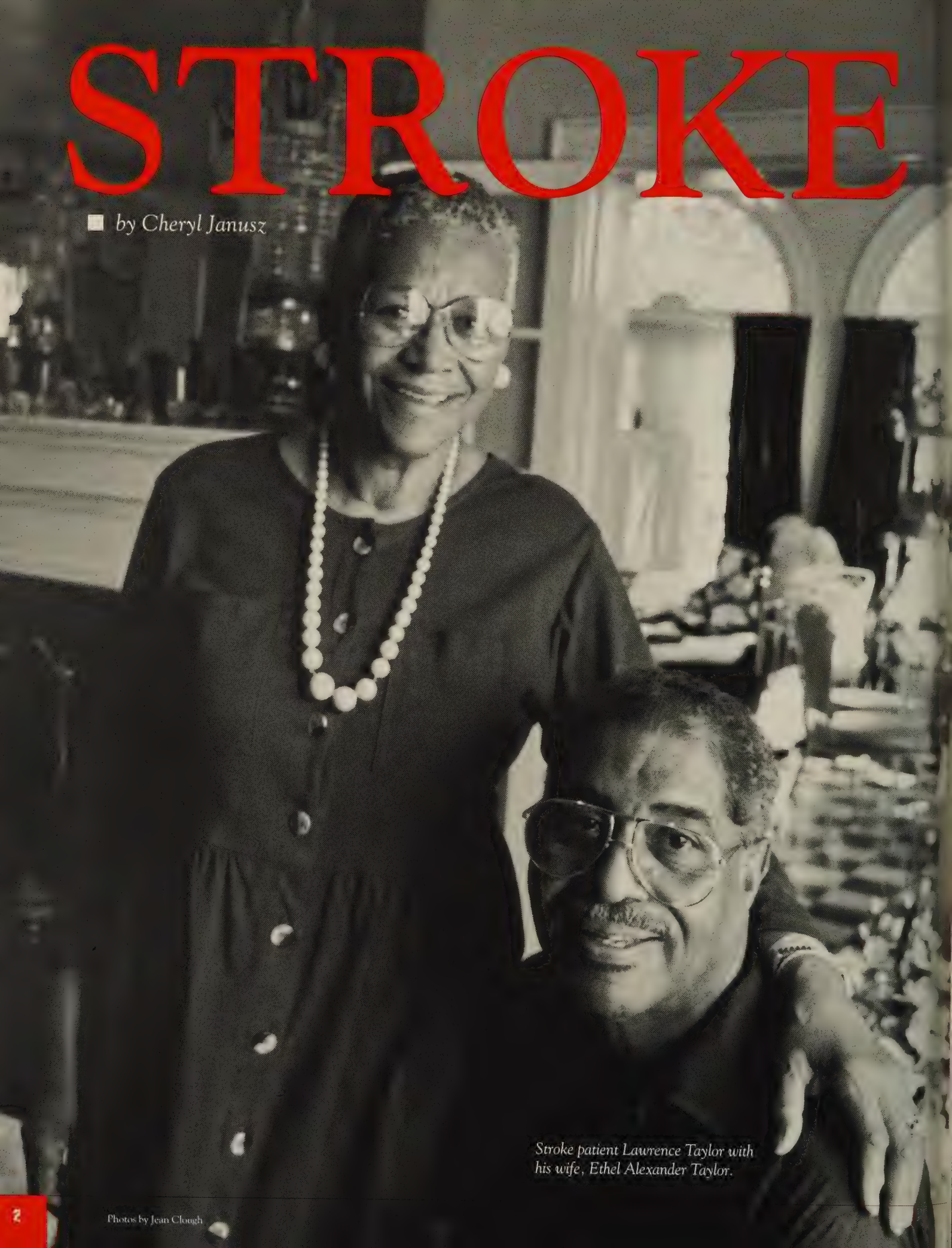
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STROKE

■ by Cheryl Janusz



Stroke patient Lawrence Taylor with his wife, Ethel Alexander Taylor.

Rush researchers seek ways to protect those hardest hit — African-Americans.

It can start with a simple blood clot, a clump of blood cells that may be no bigger than the dot on this “i.” Such clots are usually harmless and can even save a life when they form on the surface of a wound to stop bleeding.

But when a clot reaches an artery leading to the brain, the results can be deadly.

Each year, approximately 500,000 Americans suffer strokes in which blood flow to the brain is abruptly cut off, usually by a blood clot that develops in or travels to a cerebral artery. As brain cells are starved of their lifeline — blood and the oxygen it carries — they wither and die, wreaking havoc in the parts of the body they control.

The devastating aftermath, from paralysis to loss of speech and memory, makes stroke the nation's leading cause of disability. Some people are left unable to do simple things most of us take for granted, like climbing a flight of stairs, buttoning a shirt or pouring a cup of coffee.

Strokes also can kill. In fact, stroke claims more than 150,000 lives each year, making it the third leading cause of death in the United States, exceeded only by heart disease and cancer.

Rush researcher Philip B. Gorelick, MD, MPH, is now attacking the problem of stroke at its root. Armed with a \$10.8 million grant from the National Institutes of Health, Gorelick and a team of researchers at Rush and 23 other sites in Chicago and Indiana recently launched one of the nation's largest stroke prevention studies to date.

The research targets a group at singularly high risk for stroke — African-American men and women.

“There is an epidemic of stroke in the African-American community. No other racial or ethnic group has as high an incidence of stroke or as great a risk for dying of stroke,” explains Gorelick, who directs the Section of Cerebrovascular Disease of the Rush Neuroscience Institute and serves as the study's principal investigator.

African-Americans are about two times more likely than Caucasians to suffer strokes, particularly in the prime of life, between the ages of 45 and 60, says Gorelick. African-Americans felled by strokes are also twice as likely to die, or to be left disabled and unable to work, care for a family or live independently.

The new project, called the African-American Antiplatelet Stroke Prevention Study (AAASPS), will compare the benefits of two treatments that prevent the blood clots that lead to strokes — aspirin and ticlopidine. Over the next five years, researchers will track the effects of these medications in 1,800 African-American men and women between the ages of 29 and 85 who have recently suffered mild-to-moderate strokes.

“These stroke patients are a high-risk group,” says Gorelick, explaining that about half are likely to suffer another, perhaps larger and more devastating stroke within five years.

For more than three decades, the treatment of choice for people at risk for stroke has been common, inexpensive aspirin — a pill that not only relieves fevers and quells pounding headaches, but prevents the clumping of particles in the blood called platelets. Large-scale studies show an aspirin or two a day can reduce a person's risk for a second stroke by about 23 percent.

Philip B. Gorelick, MD, front row, center, with members of his research team. Back row, l-r, Rema Reman; Pete Meyer, PhD; Merryl Billingsley; Isaac Bempong, RN; Shande Chen, PhD. Front row, l-r, Yvonne Harris, Dr. Gorelick, Patricia Samuels

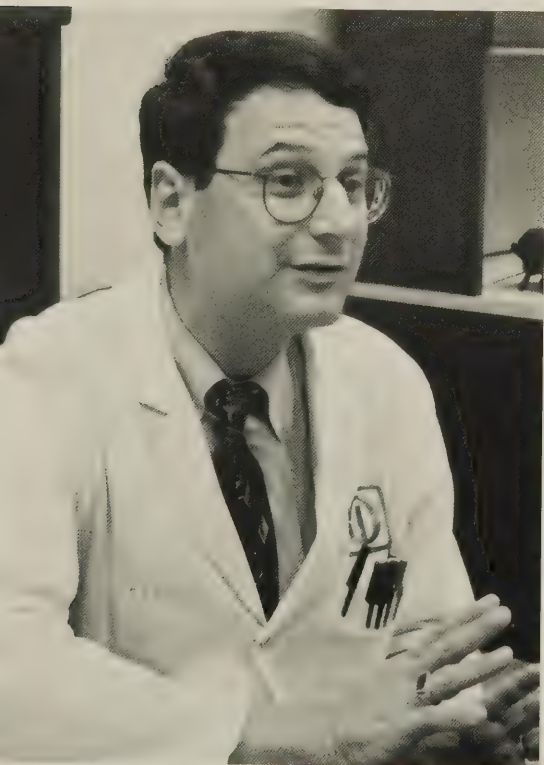


Ticlopidine also prevents the clumping of platelets, but has a broader spectrum of action. It was approved by the Food and Drug Administration in 1992 for stroke prevention.

Preliminary research suggests ticlopidine more effectively prevents second strokes than aspirin in African-Americans, possibly reducing their risk by up to 50 percent in the first year following the initial stroke. Gorelick and his research team hope to confirm this. "It would have tremendous implications for the treatment of African-American stroke patients," says Gorelick.

As a neurologist, Gorelick has been treating the aftereffects of stroke for more than two decades. As an epidemiologist — a researcher who determines risk factors for disease in relation to specific groups — he's been investigating stroke in Chicago's African-American community for more than 15 years.

Previous studies have shown that African-Americans are at high risk for all types of strokes, including those caused by blood clots — known as ischemic strokes — which tend to occur in people whose blood vessels are thickened by atherosclerosis. Ischemic strokes account for 80 percent of all strokes, while the remaining 20 percent occur when an artery in the brain bursts, causing a hemorrhage.



Philip B. Gorelick, MD, has been studying stroke in Chicago's African-American community for more than 15 years.

African-Americans' high risk for stroke may be explained, in part, by cardiovascular risks such as high blood pressure and heart disease, says Gorelick.

High blood pressure, in particular, is more likely to plague African-Americans, he says. Over time, elevated blood pressures can lead to arteriosclerosis, in which the smooth inner walls of arteries become rough and thick, and blood circulation grows sluggish, increasing the chance that clots will form.

African-Americans also have had less access to medical care, says Gorelick. The result may be that insidious dangers like high blood pressure and diseased arteries aren't detected until they lead to catastrophes such as heart attacks or strokes.

As Gorelick and his team search for the best treatment to ward off the blood clots that cause strokes, they will also gather detailed information about the study participants' lifestyles and cardiovascular health. They'll search for clues as to why African-Americans suffer more strokes — clues that may, in turn, lead to strategies to minimize their risks.

To accomplish this task, Gorelick has built an elite 81-person research team, 18 of whom staff the project's central office at Rush. This group includes statisticians who will carefully sift through the five years of data, searching for patterns and trends. Other key players include physicians and study coordinators from neurology, preventive medicine, cardiology, nephrology, hematology and pharmacology, as well as laboratory technicians, research project managers and data management personnel.

Another goal of the study is to increase African-Americans' awareness about stroke and the need for regular medical exams to check blood pressure and track other cardiovascular risks. "We want people to know they don't have to wait until they have a stroke to prevent one," says Gorelick.

Research shows that up to three-fourths of strokes are caused by reversible risks such as high blood pressure, alcohol abuse and smoking. "That's close to 375,000 strokes a year that we could prevent and tens of thousands of lives we could save each year," says Gorelick.

There's economic incentive as well, he adds. If the stroke rate were cut by just 10 percent, it could save the nation more

than \$1 billion annually in healthcare costs, according to a recent report.

To spread the word about stroke prevention, Gorelick has enlisted the help of more than a dozen former stroke patients and their families — people who have become experts on stroke through first-hand experience. To increase people's awareness about stroke risks and help recruit participants for the study, they've agreed to tell their stories to members of the media, and various church and community groups.

Some, like 63-year-old Lawrence Taylor, took part in Gorelick's earlier research. In 1989, after suffering two major strokes within the space of six weeks, Taylor agreed to participate in a Rush study exploring risks for dementia caused by stroke.

Although the study showed that African-Americans who suffer strokes could have lasting memory loss and dementia, Taylor's intellectual abilities were unaffected. Some paralysis in his left arm and leg are the only physical traces left from his strokes. "I wasn't just lucky, I was blessed," says Taylor, who lives in Chicago's Hyde Park with his wife, Ethel Alexander Taylor, a former state senator.

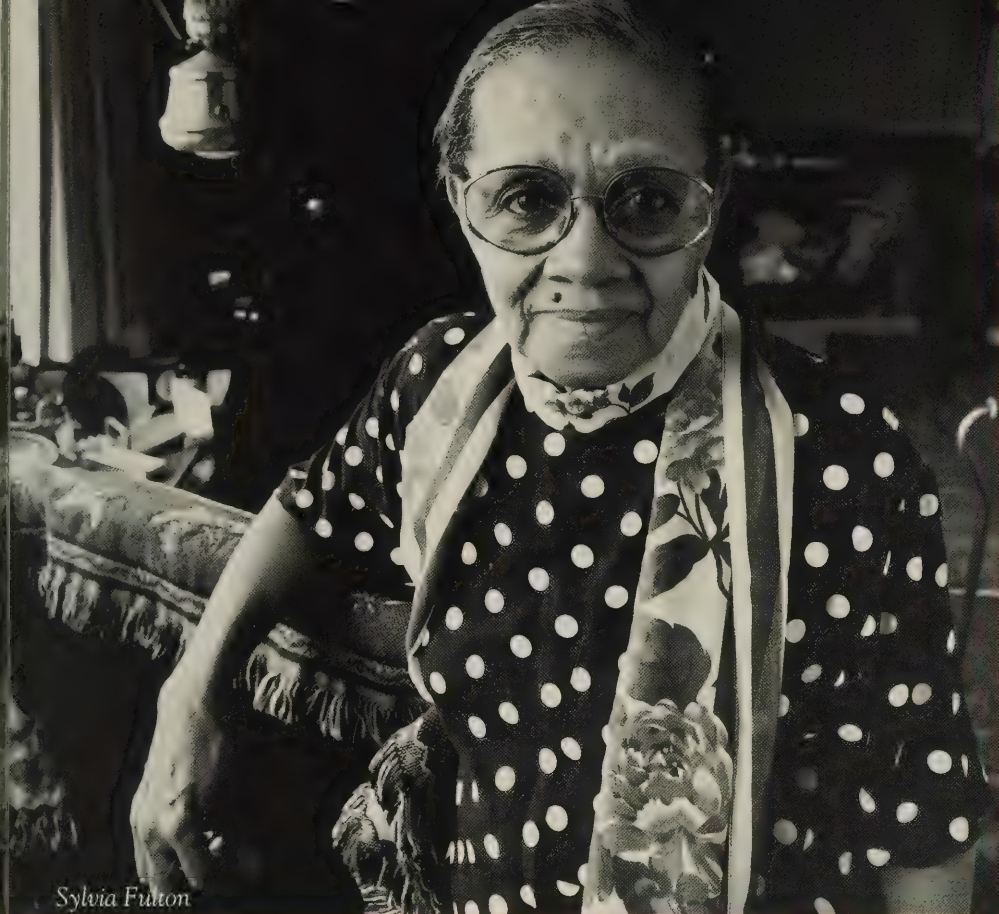
"But it was still an ordeal I wouldn't wish on my worst enemy," says Taylor, who retired from his post as a ward superintendent of the City of Chicago four years ago. "That's why we're speaking out. People need to take steps to prevent strokes before they hit."

And if a stroke does occur, adds Taylor, people should recognize that it's possible to fight back. Since his own stroke, he's quit smoking, trimmed the fat from his diet, worked regular exercise into his daily routine, and dropped 40 pounds. Medications help keep his once dangerously high blood pressure low, and his blood free of clots.

Research, he adds, offers another kind of weapon. "There's still a lot of physicians don't know about strokes in African-Americans and research is how they'll find the answers," says Taylor.

"By taking part in this kind of research, you not only help yourself, you help the whole community."

Additional information on the African-American Antiplatelet Stroke Prevention Study can be obtained by calling the Rush Center for Stroke Research at (312) 432-5200. ■



Sylvia Fulton

Heeding the body's warning signs

Sylvia Fulton's day had been particularly hectic, so that night, when her head started to throb and her speech became slurred, she blamed it on fatigue. Fulton never suspected that she — like tens of thousands of African-Americans each year — was having a stroke.

Fortunately, Fulton's daughter detected her slurred speech over the phone and called an ambulance. At the hospital, Fulton was treated with a blood-thinning medication and, within a week, she was enrolled in a stroke rehab program.

Ten years later, Fulton, now 75, still has some paralysis on her left side, but she is basically healthy. She counts her blessings. "I was ready to go to sleep that night, hoping I'd feel better in the morning," says Fulton. "I might not have made it through the night."

Because of improved treatments, quick treatment for a stroke continues to make a crucial difference.

"Immediate treatment — ideally, within six hours of the onset of stroke symptoms — can lessen a person's degree of disability. It may even save the patient's

life," explains Jeffrey Curtin, DO, who directs the Hyperacute Stroke Treatment Program at Rush.

Today, a person rushed to the emergency room in the throes of a stroke caused by a blood clot is likely to be injected with a clot-busting thrombolytic agent. These drugs derail a stroke in progress by clearing the artery and restoring the nourishing flow of blood and oxygen to the brain.

Stroke victims may also receive drugs called "neuroprotectors" which rescue brain cells that have been starved of blood and oxygen by interrupting the chain reaction that leads to cell death.

Administered in the first hours of a stroke, these treatments can dramatically reduce brain damage, says Curtin. But many people, like Fulton, don't attribute vague symptoms like headache and dizziness to stroke. Oblivious to their danger, they may fail to seek medical help for many hours, even days.

"A heart attack causes a distinctive kind of chest pain. It can wake you up from a sound sleep," says Curtin. "But the first manifestations of a stroke may be nothing more than some numbness or tingling in your arm, leg or face, which are fairly easy to ignore.

Stroke's warning signs

If you or someone you know experiences one or more of these stroke symptoms, call 911 immediately.

- Numbness, weakness or paralysis of the face, arm or leg
- Sudden blurred or decreased vision in one or both eyes
- Difficulty speaking or understanding simple statements
- Dizziness, loss of balance or loss of coordination, especially when combined with other symptoms
- Sudden severe, unexplainable headache — often described as "the worst headache of your life"

"People are often hesitant to come to the emergency room because they're afraid that if the symptoms are nothing serious, it's a nuisance," he says. "But I'd rather evaluate 15 people in the emergency room for symptoms that prove trivial than miss one stroke."

At Rush, Curtin is testing several new stroke treatments. One, a drug called eliprodil, is a neuroprotector that stops the build-up of deadly toxins in oxygen-starved brain cells, preventing cell death.

Curtin is also studying a new way of administering the powerful clot-buster, pro-urokinase. Currently, this medication is injected into a vein in the stroke patient's arm or hand. The new method, however, lets physicians inject the drug directly into the clot, by means of a catheter threaded up through the main vessel in the neck, the carotid artery.

Curtin is comparing the two methods. "There's evidence that injecting the drug into the clot is more effective, but it can take up to an hour to place the catheter — time that is extremely precious when you're dealing with a stroke," he says. "We may find it's more effective to use the quicker intravenous method."

— C. Janusz

1895



*Wilhelm Conrad Roentgen
discovers X-rays*

1895



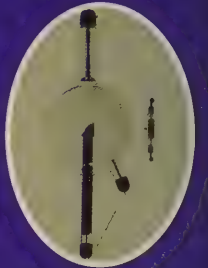
First X-ray of a hand

1898



X-ray room at Rush

1898



Roentgen tube



XRAY

The chance discovery of X-ray in 1895 launched one of the most influential fields in 20th-century medicine.

■ by Dennis Connaughton

When Robert Blair came to Rush in the summer of 1994, his heart was failing. It seemed that his best hope would be a heart transplant.

Before making a decision, however, physicians examined Blair's heart with a new technology called positron emission tomography (PET) that produces vivid pictures of the body's metabolic activity. PET scans showed that although Blair's heart was weak, a significant amount of the heart muscle was still working and a transplant could be avoided. Based on these findings, Blair had bypass surgery at Rush last fall and his heart condition improved dramatically.

PET is one of a host of high-tech imaging techniques that let physicians explore the body's innermost workings without making an incision. It is the latest in a series of developments in radiology that have advanced medicine.

"Diagnostic radiology now plays a role in the diagnosis, and often the treatment, of virtually every medical condition," says Jerry P. Petasnick, MD, who has chaired the Department of Diagnostic Radiology-Nuclear Medicine at Rush since 1989.

It all started with a chance discovery a century ago. On Nov. 8, 1895, a German physicist named Wilhelm Conrad Roentgen was experimenting with cathode rays when he made one of the most significant findings of his era and ours — X-rays.

X-rays are a form of electromagnetic radiation — like radio waves or visible light, but carrying much greater energy. Roentgen's demonstration of X-rays mesmerized the scientific community when he produced images of his wife's hand, with her wedding ring and her finger bones clearly visible. He passed electromagnetic radiation, generated in a vacuum tube, through her hand and onto a photographic plate.

In an X-ray, dense structures such as bone and the metal in a ring absorb radiation and appear white on photosensitive film. Human organs such as the heart, lungs and intestines, however, are less dense and absorb less radiation. On film, they appear black or gray. Because bones show up so clearly on a black background, physicians first used X-rays to diagnose broken bones and kidney stones. Over the next 70 years, however, their use was extended to the diagnosis of tumors, tuberculosis and various tissue abnormalities.

X-ray techniques were refined throughout the 1950s and '60s with the introduction of contrast agents, chemicals that allow X-rays to detect an outline of such organs as the stomach, and radioisotopes, radioactive materials that allow X-rays to show how an organ works.

In 1971, however, radiologic imaging entered a new dimension when X-rays met and married the computer.

Their offspring was computed tomography, or CT scanning. In CT scanning, a series of X-ray exposures — perhaps up to 1,000 or more taken from various angles in a large donut-shaped machine — are analyzed by a computer and compiled into two-dimensional, cross-sectional images of various organs.

CT offers views of the body that were possible before only by slicing through an organ with a scalpel and taking a look, explains Petasnick, who was a radiologist at Rush when the Medical Center installed the Chicago area's first CT scanner in 1973.

"I thought it was the most exciting advance I would ever see," he recalls. "Two decades later, CT is still invaluable, often offering the best way to determine the shape and size of cancers, the presence of infection, and the extent of bleeding caused by trauma."

CT was a model for other advanced imaging tools that were born of computer technology that reconstruct images of the body's organs and systems from massive amounts of data collected electronically.

The first of these other tools, magnetic resonance imaging, or MRI, introduced a completely new way to obtain images of the body's interior. MRI relies on a powerful magnet, housed in a large scanner. Radio waves are passed through the body, causing hydrogen nuclei in the body to send their own radio signals to the machine. A computer then translates these signals into images.

The MRI scanner creates images from every direction and plane, providing greater contrast in images of soft tissues than CT scans or X-ray film. The technique is useful for diagnosing small tumors, lesions in the brain and spine, aneurysms, bone-marrow disorders, and muscle and bone diseases.

Since Rush obtained one the nation's first three MRI units in 1983, physicians have used the technology extensively in diagnosis and, more recently, planning of treatment. In one of the newest

applications, Rush neurosurgeons use MRI to guide a delicate brain surgery for severe Parkinson's disease.

MRI is offering insights in brain research as well. Radiologists at Rush have combined MRI with sophisticated computer programs to help neurologists study anatomical changes that occur in the brains of people with Alzheimer's disease. And working with scientists at California's Stanford University, Rush researchers are using MRI to "map" the brain's electrical activity and learn more about the organ's function.

"As we image people's brains, they are asked to perform certain actions — to tap their fingers or answer certain questions. The part of the brain that controls that activity lights up in the images, after they are processed by a computer," explains radiologist David Turner, MD, who is assisting neuroscience researchers Frank Morrell, MD, and Glen Stebbins, PhD.

Over the past decade, other computer-based imaging techniques have broadened

the possibilities in medicine's quest to understand the mysteries of the human body. They include PET, or positron emission tomography, a research tool developed by U.S. scientists in the 1970s that is now gaining increased clinical use.

Rush's PET scanner is the first in Chicago to be used for patient care and one of only 30 such scanners in use nationwide. Images obtained with PET tell doctors how various organs are working by tracking radioactive materials — radioisotopes — that have been injected into a patient's body. The radioisotopes gravitate to viable cells, producing color "hot spots" on a printout.

For some illnesses, such as forms of heart disease and cancer, PET provides much more information than CT and MRI. PET technology also makes it possible to diagnose a number of brain disorders in early stages. "No other imaging technology does what PET can do," says Amjad Ali, MD, medical director of the Rush PET Center. "It really is a remarkable tool because of what it can tell us about

certain organs or body systems in action."

Computers make innovative techniques like PET possible, and they are advancing the practice of radiology in other ways as well.

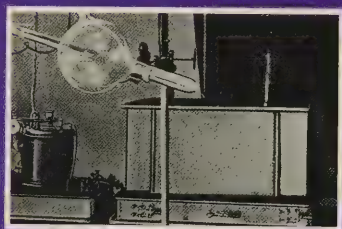
At Rush, for example, radiologists now rely on computer networks to instantly transmit CT and MRI images to various departments around the Medical Center or, in some cases, to other hospitals. "Physicians can get the vital information they need to make diagnoses and determine treatments more quickly than ever before," says Petasnick.

But when the field of radiology celebrates its bicentennial in 2095, says Petasnick, the space-age technologies that now leave us in awe will probably seem as archaic as X-ray film.

"More than half of what I do today involves technologies I never dreamed of as a resident in the mid '60s," he says.

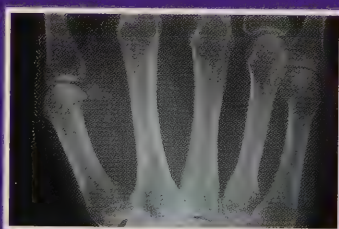
"Radiology isn't a field where you can sit back and do things the way they were done 10 years ago. You have to keep moving ahead with the technology." ■

1903



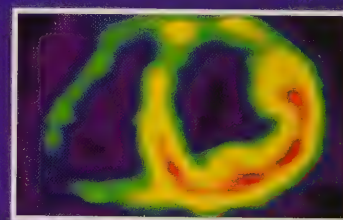
X-ray outfit

1960



Conventional X-ray

1995



PET scan

X-RAY INTRODUCED AT RUSH

X-ray was introduced at Rush in 1898, when benefactors William and Edward Blair gave \$498.33 to Presbyterian Hospital to buy equipment and establish the first X-ray department. The money bought a simple coil that generated an electric spark, a storage battery and a hand-made Crooke's vacuum tube. By 1903, the hospital's annual report described the X-ray department as "the most complete of its kind west of New York," with three X-ray machines and a waiting room for patients.

The fledgling department was opened by medical student Joseph F. Smith, who graduated from Rush Medical College in 1900. Known as "X-ray Smith," he ran the department in what was then the attic of the Jones Building until 1906, when he went to study in Vienna.

Smith was succeeded in 1907 by another Rush student, Hollis E. Potter, who graduated in 1908. Potter was

selected because he taught chemistry and physics, and was interested in photography.

Potter developed a significant improvement in X-ray machines by devising a moving grid that blocked scatter radiation — radiation that bleeds outside the field of focus, much like the halo around a beam of light from a flashlight focused on a wall. Minimizing scatter is a safety factor in radiology and particularly important in radiation therapy for cancer, in which precise targeting of a tumor is essential.

Other key figures in Rush radiology include 1914 Rush Medical College graduate Cassie Bell Rose, MD, who led the Department of Radiology from 1922 to 1937; Fay Huffman Squire, MD, who led the department from 1937 to 1950; and Richard E. Buenger, MD, who led the department from 1969 to 1989. ■ — D. Connaughton

Gaining Momentum

■ by Denise Van

One summer night in 1977, Marca Bristo lost a pair of shoes off the pier at Chicago's Pratt Boulevard Beach. The young nurse dove into Lake Michigan to retrieve them and broke her neck. At 24, she became a quadriplegic.

Eighteen years later, she is a nationally recognized advocate for the rights of the disabled. Bristo, 42, who earned a bachelor of science degree in nursing from Rush College of Nursing in 1976, is the president and chief executive officer of Access Living, a Chicago program that helps people with disabilities learn to live independently. She manages 30 employees and a \$1.9 million budget.

Bristo is also a presidential appointee, serving as chairperson of the National Council on Disability, the independent federal agency that drafted the original

"The events and social movements of the '60s and '70s shaped my life as much as the disability did."

version of the 1990 Americans with Disabilities Act. She travels frequently to Washington for meetings and has speaking engagements throughout the nation.

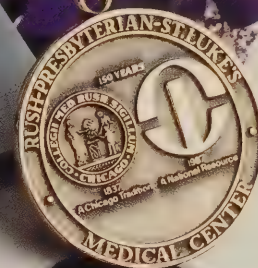
In June, Bristo was awarded the 1995 Rush Trustee Medal, given to honor an individual connected with Rush who has made a significant contribution to medicine and health. She also received the College of Nursing Distinguished Alumna Award.

Bristo's contributions to the fight for independence for disabled people come from a deep well of thought fed by ideas and events that stretch back through her life.

It wasn't only the accident that made her an advocate for the disabled, she says. "The events and social movements of the '60s and '70s shaped my life as much as the disability did."

Bristo says she had a storybook growing up on a farm and in a tiny town in upstate New York. "It was so normal — or so 'abnormal' — no diversity, no conflict. But those '70s events — the Vietnam protests, the very early women's movement, the gay movement — made me question what I considered to be the normal order of things. Learning that what you see is not what

Marca Bristo
age 41 President and
chief executive officer of
Access Living Nation's top
"accessibility" advocate
The vibrant, aggressive Bristo rocketed
to a position of national prominence with
the 1990 passage of the Americans with
Disabilities Act. Last year, she was the
TV segment about the act was a
groundbreaking moment from her
that she...



FAMOUS CHICAGOANS YOU

Rush College

for that degree
Chicago...

you get gave me a challenging spirit.”

After earning a bachelor's degree in sociology from Beloit (Wis.) College, and propelled by the women's movement, she decided to become a midwife. “I was in pursuit of social change through the healthcare professions,” she explains. Bristo enrolled in the Rush College of Nursing, and worked in labor and delivery at Rush following her graduation. She was a nurse at Chicago's Northwestern Memorial Hospital when the accident happened.

Suddenly faced with the prospect of spending life in a wheelchair, Marca Bristo refused pity from well-meaning friends and started to deal with her own unexpressed feelings about disabled people.

“Suddenly, I was the victim of my own discriminatory attitudes towards the disabled. I had limited exposure to disabled people. I didn't think about them, but they were there, tucked away and out of sight. The stereotype was negative, and I was never challenged to think about it until the accident,” she says.

She admits, “I was angry after the accident. I was neither like I was before nor had I become the person I would become — one who today feels proud of being a person with a disability.”

She dealt with the reality of disability. “Rehab is a nuts-and-bolts process, with a

beginning and an end,” she explains. “You cross terrain — like bodily functions — that you've already been through, but you retrace old ground in a whole new way. I came out at the other end different, and the same.”

Bristo returned to work at Northwestern's women's and children's clinic, which made accommodations for her wheelchair. And she crossed well-known terrain, getting from her apartment to a nearby grocery in her wheelchair. Now, two curbs blocked her way and made the trip difficult. “I thought it was my problem that I couldn't negotiate

“The disabled rights model recognizes that the limits are in society, not in the individual.”

them,” she recalls. “It never dawned on me that there was something wrong with the curbs!”

Her work on the Americans with Disabilities Act has removed thousands of curbs. Today, towns and cities all across the country are doing away with them, making pedestrian crossings navigable by people who use wheelchairs and other assistive devices such as canes and walkers to get around.

In 1979, Bristo helped found Access

Living, directing the agency when it was affiliated with the Rehabilitation Institute of Chicago and into its present full corporate autonomy in 1987.

As a full-time executive, Bristo uses skills she learned in the Rush College of Nursing. “Rush helped me get organized,” she laughs. “Helped me develop the administrative side of myself. Nurses always have too much to do so they have to learn to prioritize.”

In her advocacy for the disabled, Bristo uses the nursing paradigm of putting patients first. Access Living is run by the people who need it and use it — the majority of its board and staff members are disabled.

“But the medical model, as it relates to disabled people, fosters dependency,” she explains. “When you live with a chronic disability, all the good medical care in the world doesn't help that disability. After a point, the therapy is done and fixing isn't in the cards.”

“The disabled rights model recognizes that the limits are in society, not in the individual. For too long, we've defined humanity incorrectly, saying there are people and then there are ‘others.’ Public policy excluded the disabled, segregated them in special schools and jobs, saying they are ‘special,’ instead of saying that it's normal for humans to be varied. And it supported dependence, forcing

continued on page 27

Marca Bristo, far right, among the honored guests at the July 1994 White House celebration of the fourth anniversary of the Americans with Disabilities Act.



chance to grow up...

■ by Barbara Harfmann

Aggressive treatment lets a young cystic fibrosis patient play like a typical boy.

Watching kindergartner John Weyland race around his backyard or jump on his bed with his best friend, Ben, no one would suspect he nearly died before his first Christmas.

John, 6, has cystic fibrosis, a genetic disease that attacks the lungs and pancreas, making it difficult for him to breathe, and for his digestive system to break down food. One in every 2,000 children is born with cystic fibrosis — the most common life-threatening inherited disorder among Caucasians.

Cystic fibrosis affects the exocrine glands, which normally produce thin, slippery secretions including sweat, mucus and saliva. The disease causes the body's mucus to become thick and sticky, clogging the lungs and pancreas.

"When you cough, you exhale all the dirt that has gotten into your lungs," says John D. Lloyd-Still, MD, who directs the Cystic Fibrosis Center of the Rush Children's Hospital. "But the sticky mucus in the lungs of people with CF traps dirt and germs. They're coughing constantly as their mucus becomes thicker."

Rush's Cystic Fibrosis Center is dedicated to the care and treatment of children, adolescents and adults with the disease. John has checkups at least four times a year by a multidisciplinary team, including a pulmonologist, gastroenterologist, a nurse with special training in cystic fibrosis, a dietitian, respiratory therapists and a social worker.

Patients like John are vulnerable to respiratory infections, progressive lung disease, and digestive problems.

John, for example, was born with meconium ileus — a form of bowel

Photos by Jean Clough

obstruction that is a telltale sign of cystic fibrosis. Just two hours after birth, John was airlifted from a community hospital in his hometown of Woodstock to Rockford, Ill., where two-thirds of his small intestine was removed. He spent his first year of life in and out of the hospital, battling severe lung infections, intestinal problems and an inability to gain weight.

Tests performed by the hospital to confirm cystic fibrosis came back negative. But John's mother, Shari, whose brother died of cystic fibrosis at age 19, was convinced her son had the disease.

"He wasn't digesting his formula well and couldn't maintain his weight," she says. "We were regulars in the intensive care unit. It was like being on a roller coaster."

Another test, performed about two months later at the insistence of Shari and her husband, John Sr., confirmed that their son had cystic fibrosis. The couple then made a 60-mile trip to meet with pediatric gastroenterologist and renowned cystic fibrosis expert Lloyd-Still, who at that time directed the Cystic Fibrosis Center at Children's Memorial Hospital in Chicago.

Lloyd-Still remembers how sick John was.

"The kid was a wreck. At 2½ months, he weighed less than his birth weight," recalls Lloyd-Still. "A few months later, he developed respiratory failure and lung infections so severe that I didn't think he was going to make his first Christmas."

Aggressive treatment saved John's life. Aerosol therapy, in which John inhaled a fine mist of antibiotics and other medications through an oxygen mask, helped thin out sticky secretions and fight off lung infections. Respiratory therapists also pounded on his back to help loosen secretions.

Because John couldn't absorb enough calories to sustain his weight, he received slow-drip liquid feedings through a tube that passed through his nose into his stomach. Ultimately, he had surgery to place a gastrointestinal tube permanently into his stomach. Then, at age 2½, John was diagnosed with diabetes, a disease that usually develops in older cystic fibrosis patients because the malfunctioning pancreas can no longer produce enough insulin.

Four years later, John continues to receive daily insulin shots and liquid nutrition. Controlling John's diabetes presents more day-to-day problems than his cystic fibrosis since he hasn't had

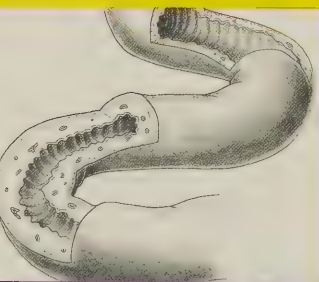


John Weyland (left) shows his best friend, Ben Pacey, how to use a "flutter valve." John, who has cystic fibrosis, uses the valve to keep his lungs clear of dirt and germs.

any major intestinal or lung problems in almost two years. But his parents and doctors know that can change.

"Cystic fibrosis is a slow, tricky disease," says Lloyd-Still. "You can't tell that John and many of our patients are sick, particularly those who are diagnosed and begin treatment early. But by the time they're in their teens, lung infections become a major problem." *continued on page 27*

A Better Way to Study Digestion



The colon of a cystic fibrosis patient may become thickened with scar tissue, increasing the risk for painful bowel obstructions.

Illustration by Kristen Wienandt

problems, possibly caused by the very medications that help them digest food.

This year, researchers with the Rush Children's Hospital reported on a new method to study intestinal function that is revolutionizing research in cystic fibrosis and other diseases that affect digestion. Using laboratory rats, neonatologists Robert E. Kimura, MD, and Michael Uhing, MD, are studying how nutrients and other chemicals in food and medication are absorbed by living beings.

The rat model they have developed will help scientists study malfunctions in the small intestines of cystic fibrosis patients. Doctors suspect these intestinal problems are caused by long-term use of pancreatic enzymes, which patients take to replace enzymes the diseased pancreas fails to secrete.

Hailed by the scientific community in an editorial in the July 13 issue of the international scientific journal *Nature*, the model holds enormous significance for the study of intestinal absorption. "Most

Thanks to improved treatments, more cystic fibrosis patients now survive well into adulthood. But those who live longer tend to develop new complications — including painful intestinal

previous research involved cells, tissue slices and studies on intestines exposed to surgical conditions," explains Kimura. "The research conducted under these artificial conditions didn't reflect what happens in real life."

According to the researchers, the Rush model is more physiologically accurate because it more closely mirrors how living animals actually absorb what they eat. The model has also provided scientists with a way to clarify how the intestine interacts with the liver, which helps the body digest and store nutrients. This complex relationship has never been well understood.

"We're just starting to realize the enormous implications of this work. It's the future of research with this model that's exciting," says Kimura, who has studied digestion for more than 20 years.

The researchers hope that one implication will be less pain and discomfort for older cystic fibrosis patients, whose intestines tend to thicken and scar, resulting in frequent blockages. John Lloyd-Still, MD, director of the Rush Cystic Fibrosis Center, has theorized these intestinal problems are caused not by the disease, but by long-term use of pancreatic enzymes, a treatment required by virtually all patients.

Using the new model, Lloyd-Still and the researchers will study the link between pancreatic enzymes and intestinal problems, and search for a way to prevent this complication.

"As researchers, our goal is to bring our work as close as possible to real life, to better help patients," says Kimura. "We now have a system that will let us do just that." ■

— C. Janusz

For most of us, getting ready for bed means little more than brushing our teeth and slipping into those cozy Speed Racer pajamas. But for some, it just isn't that easy.

Marilee Jensen, of Mundelein, Ill., for example, wouldn't dare hit the sack without her tongue-retaining device, a rubber gadget that resembles something you'd be more likely to find on a professional boxer than on a 62-year-old suburban retiree.

Others' bedtime rituals include strapping adhesive bandages to their noses, and still others wouldn't dream of facing the sandman without their tennis balls — that's right, tennis balls.

So why is everyone cluttering up the Serta with all this hardware?

It's all in the quest for a good night's sleep.

More and more people are turning to these and other devices to fight that dreaded nighttime nemesis that gets the neighborhood dogs howling and drives spouses onto the living room sofa: Snoring.

As comical as they may sound, however, these gadgets have helped some of America's 25 million snorers control a problem that's not only bothersome to bedpartners, but can warn of more serious health problems.

Snoring results when the upper airway in the throat is partially blocked by the tongue and other muscles that relax during sleep. The snoring sound is created by air flowing through the nose and mouth, and vibrating the soft palate — the tissue in the roof of the mouth near the throat — like pipes of an organ. The lips, nostrils and cheeks may vibrate along with the soft palate, making the snoring louder.

Most snorers are older men, and many of them are overweight. According to Rosalind Cartwright, PhD, director of the Rush Sleep Disorder Center, snoring is more common in heavier men because larger muscles and more fatty tissue in the tongue and throat make the airway smaller. Alcohol can also contribute to snoring by relaxing these muscles even

more, and smoking can cause the tissues to become inflamed.

Apart from the irritation it causes others, most snoring is harmless. However, loud irregular snoring can point to a more serious condition called obstructive sleep apnea syndrome, in which complete blockage of the airway causes the snorer to actually stop breathing for extended periods — from 10 seconds to more

may be the answer, Cartwright says.

Tongue-retaining devices, for example, work by pulling the tongue forward to keep it from falling back and blocking the airway, like a cork in a bottle. The retainer also keeps connected tissues taut, cutting down on vibration during breathing.

Cartwright and her staff have fitted hundreds of patients with the device since it was invented in the late 1970s by a former Rush psychiatrist. But she's quick to point out that it's not right for everyone.

"Some people can wear it right away and are very happy with it. Others can't tolerate it in their mouths. They find it too uncomfortable," she says.

Cartwright is now helping a California dentist test a smaller retainer that they hope will be more comfortable. Unlike the older model, the new, one-size-fits-all device — being tested at Rush and Stanford University — doesn't have to be tailored to each patient's mouth. Dozens of similar devices have been designed by other doctors and dentists as well.

Gadgets silence snorers' nocturnal noises

■ by Jeffrey B. Meyers

than a minute — and wake up gasping for air. This condition can lead to serious medical complications like high blood pressure, heart problems and stroke, and should be treated immediately.

But for those suffering from "benign snoring" — steady, rhythmic snoring throughout the night — simple gadgets

Marilee Jensen, who was fitted with a tongue-retaining device at Rush last year, says the gadget keeps her from snoring, but she finds it too uncomfortable to wear every night.

"I wear it only when I'm extremely tired, because that's when I snore the loudest," she says. "Other nights my snoring doesn't bother my husband."

Those who find tongue retainers

unbearable might have better luck confronting the problem from another angle. Because most snorers find their problem is worse when they sleep on their backs, training a snorer to roll over may help.

To help snorers get used to sleeping on their sides, Cartwright has developed a number of "sleep-positioning trainers," including a tight-fitting T-shirt that features a long pocket that runs along the spine. The pocket is designed to hold tennis balls or, for really deep sleepers, harder whiffle balls. The discomfort of trying to sleep on the balls forces even the deepest sleeper onto his side, Cartwright says.

"It doesn't wake snorers up — they just move over and avoid it," she says. "It's a nice silent trainer and it has worked for many people."

Another position trainer that wasn't as successful is a small alarm that can be strapped to a snorer's chest just before bedtime. When the sleeper rolls onto his back, he is awakened by a piercing electronic beep, which subsides when he turns onto his side. The alarm features a 15-second delay to account for tossing and turning.

Cartwright says she stopped prescribing the device, which she helped to design.

"I've given up on it, because it often wakes up the spouse, too," she says. "And some heavier snorers sleep right through it, even though it's a very ugly noise."

If beepers and balls aren't your game, there are lots of other devices out there. Currently popular is a Band-Aid-style tape that fits over the bridge of the nose and, according to manufacturers, provides better airflow through the nasal passage. The over-the-counter device is also popular among football players and other athletes who believe it helps them breathe easier during strenuous exercise.

These are just a few of a growing number of devices available to snorers. "There's a whole roster of gadgets that the dental profession is coming out with," Cartwright says. "There's a new one every day."

So how is a snorer to know what's right for him? Cartwright suggests trying different devices until you find one that's effective and comfortable. If gadgets

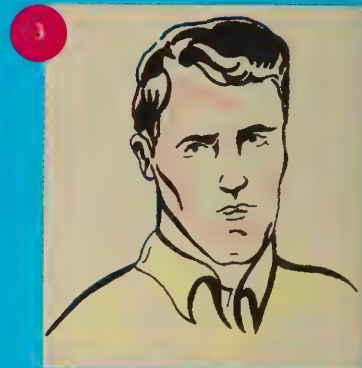
One, two, three, snore One, two, three, snore

Can't stop snoring? Get that mouth in shape.

If fancy gadgets haven't muffled your nocturnal noises — or if you're of the opinion that tennis balls belong on the court and not in bed — try these simple exercises twice a day to tone sagging muscles that can contribute to snoring.



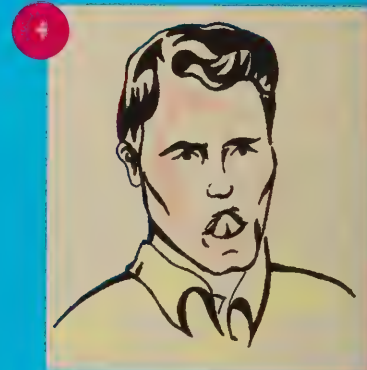
1) Firmly hold a tongue depressor or a wooden spoon between your teeth for five minutes. Keep the pressure on, even when your jaw muscles start to feel fatigued. This develops the muscles you use to open and close your mouth.



3) Firmly press your tongue against your lower teeth for three to four minutes. This will strengthen the muscles at the back of your tongue to keep it from falling back and blocking your airway at night.



2) To firm the muscles that keep your lower jaw in a forward position, place your fingers against your chin and press firmly for two or three minutes while you hold your jaw steady.



4) To further develop the tongue muscles, stick out your tongue and try to touch the tip of your tongue to the tip of your nose. Repeat.

Each day it should take a little longer for your muscles to become fatigued. Enjoy your workout!

don't seem to work, try some exercises to firm up fatty tissue in the mouth and throat (See box). Most important, whatever method you try, don't put off addressing the problem.

"It's hard to share a bed with a snorer," Cartwright says. "This is something you want to deal with quickly — before the spouse moves into the guest room or out the door." ■

Rush MD

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A MATTER OF COSTS AND SENSE

Sexual Harassment in Medical Education

By Sue Jeantheau

IF THE FIELD of medicine is a microcosm of today's society, then we should not be surprised that sexual harassment is a problem in the field, says Lois Margaret Nora, MD '80, JD. Its costs to the academic medical community remain immeasurable, but not unexamined.

Nora, a former faculty member of Rush Medical College and now associate dean of academic affairs at the University of Kentucky College of Medicine, has reviewed the medical and legal literature and has conducted studies about the perceptions and effects of sexual harassment in the academic medical environment. She says sexual harassment is common, varies across specialties and is largely unreported.

"The interest in sexual harassment in medical educa-



tion stems from a general concern about the environment that students experience in medical school," says Nora, who notes that the first literature on the subject appeared in 1982. "Faculty and students had a sense that students were being mistreated."

According to the literature, mistreatment includes everything from name-calling

to being pushed or shoved, using sexist slurs or offering rewards for sexual favors. Some studies have reported that up to 90 percent of medical students, both men and women, have experienced mistreatment or sexual harassment at the hands of other medical students, residents or attendings. But because researchers and their study

subjects can have different perceptions of what mistreatment is and what form of mistreatment determines sexual harassment, even the best research inadequately defines the problem's scope, she says.

Perceptions and definitions aside, Nora says the issue of sexual harassment begs the attention of the academic medical community. She notes the lost training opportunities for students who don't wish to learn from those who have abused them. She also points out the increased depression and alcohol use among students who are harassed, and perpetuation of behaviors by the harassers into their residencies and beyond.

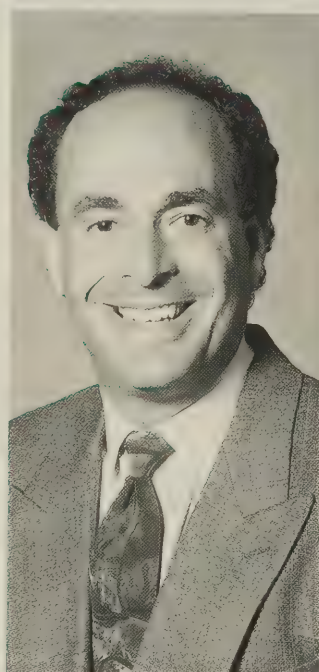
Institutions where sexual harassment and general gender discrimination exist also

continued on back page...



Alumni Support Can Help Decrease Financial Burden on Rush Students

By Harold A. Kessler, MD '74, President, Rush Alumni Association



"Graduating students are facing enormous debt at a time when their earning potential is being rapidly eroded ... Those of us who are 10 years or more out of school have probably forgotten what a burden this is."

— Harold A. Kessler,
MD '74

AT THIS YEAR'S commencement ceremony, Dean Erich E. Brueschke, MD, commented on the future of the medical students he was presenting for their diplomas. He mentioned their long working hours yet ahead, as well as the prospects for managed care in the 21st century and the students' piling debt.

As I listened, it struck me that he was focusing on issues that are absolutely central to the Alumni Association and to my work as your president for the next two years.

FINANCIAL CHALLENGES

Everyone is beginning to feel the impact of the changes taking place in health care. Medical students are also affected by these changes.

There are fewer opportunities for federal funding and there is decreasing reimbursement. So, graduating students are facing enormous debt at a

time when their earning potential is being rapidly eroded. And, the length of time they'll likely spend paying back that debt is growing longer.

Those of us who are 10 years or more out of school have probably forgotten what a burden this is. What we need to appreciate is how much more difficult it's going to be for incoming medical students—many of whom will leave school \$100,000-plus in debt—to get out of that huge hole.

ALUMNI SUPPORT

So what can we do as alumni? We have to continue to ease the burden on our students—a burden that continues to grow (See chart). To do that, we must increase our commitment to giving.

Currently, 28 percent of alumni from all classes contribute. I'd like to see that number increase to 35, 40 or

even 50 percent. And we can start to do this by tapping into the relationships we have with one another.

Some of our fellow alums haven't heard about the great work the medical school has been doing or about the needs of our students. If you've actively supported the Alumni Association, you know about this work. Share this information with other alumni. Encourage them to be a part of this commitment.

I plan to start right here at Rush with all of the alums who are on staff at the institution and to network out from there. If everyone reading this column could reach someone who hasn't read it, we would be a step closer to meeting our goal of increasing our commitment.

	1991	1992	1993	1994	1995
Total Debt	\$6,868,371	\$6,627,201	\$7,271,039	10,502,115	\$8,671,228
Number of Graduates with Debt	96	91	95	113	97
Average Debt per Graduate	\$71,545	\$72,826	\$76,537	\$92,939	\$89,394

1995 DISTINGUISHED ALUMNUS

G. Howard Gottschalk, MD '40, Honored for Holistic Approach to Medicine

By Gary Mans

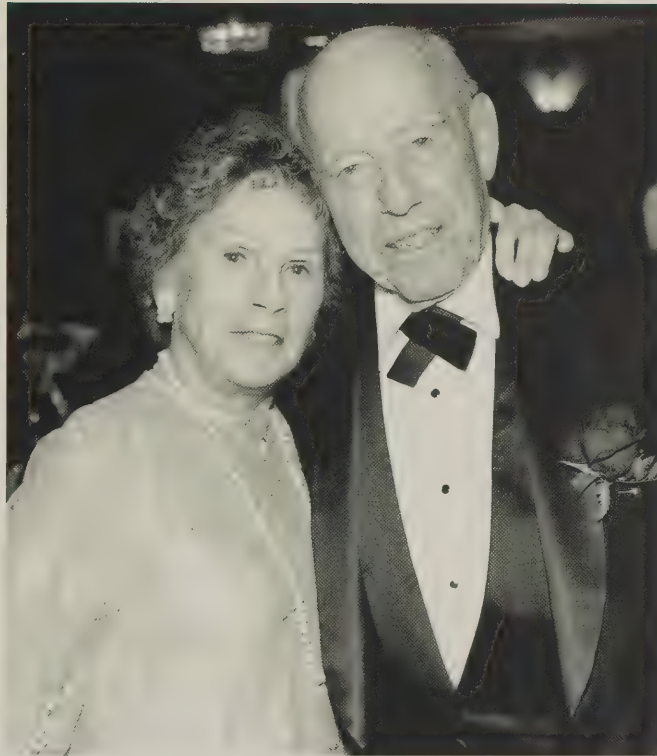
ONE OF THE MAJOR criticisms of the medical profession today is that physicians are too specialized, treating specific ailments at the expense of helping the whole person.

This year, the Rush Medical College Alumni Association recognized an alumnus who is an exception to this rule by naming G. Howard Gottschalk, MD '40, its 1995 Distinguished Alumnus.

Gottschalk, who lives in Los Angeles, Calif., has maintained a private practice in otolaryngology since 1948. Despite his specialization, he was honored for his holistic approach to treating patients.

Gottschalk says that Rush prepared him for this approach by offering a complete survey of medicine—an education that taught him to recognize the symptoms of many diseases, not just the disease being studied in a particular clinic. "Thus, each patient became a compendium of all the fields of medicine and our interest was not confined to only one system, but to the patient as a whole," he says.

Carrying this philosophy into his private practice and research, Gottschalk continues to strive to provide the best treatment with as little discomfort to patients as possible.



1995 Distinguished Alumnus G. Howard Gottschalk, MD '40, with his wife, Ann, at the Rush Commencement Banquet this past June.

One result of this attitude is his development of a new method to control severe nosebleeds.

"When I was a resident, and later in private practice, I packed many hundreds of noses to control severe nasal hemorrhages," explains Gottschalk. "The treatment

was most uncomfortable for the patients."

Now, if a patient has a severe nosebleed, a physician can control the bleeding using a small catheter tipped with a tiny balloon, known as the Nasostat balloon catheter, designed by Gottschalk. The catheter is inserted into the

patient's nostril and the balloon is inflated to put pressure on the bleeding vessels. This constant pressure stanches the blood flow.

"This treatment is more effective and less traumatic for the patient than packing the nose with gauze," says Gottschalk.

Gottschalk's main research interest is in the treatment of a disease that causes 40 percent of mild to moderate hearing loss in children—ear infections. He continues to seek treatment options that eliminate the need for children to face surgery to correct the problem.

His dedication to treating his patients has not gone unnoticed. Gottschalk is the past president of the Centinela Valley Branch of the Los Angeles County Medical Association, the Los Angeles Society of Otolaryngology, the Westchester Medical Society and the Medical Staff of the Centinela Hospital Medical Center. In addition, he is an assistant clinical professor emeritus of otolaryngology at Loma Linda Medical School in California.

1995

Alumni WEEKEND



OLD FRIENDSHIPS WERE renewed—and new bonds formed—when members of the classes of 1935, 1940, 1975, 1980, 1985 and 1990 gathered at Rush for Alumni Weekend 1995. Alums traveled to Chicago from all corners of the country, even Hawaii, to reminisce about their days as students and see off a new group of graduating physicians, the Rush Medical College Class of '95.

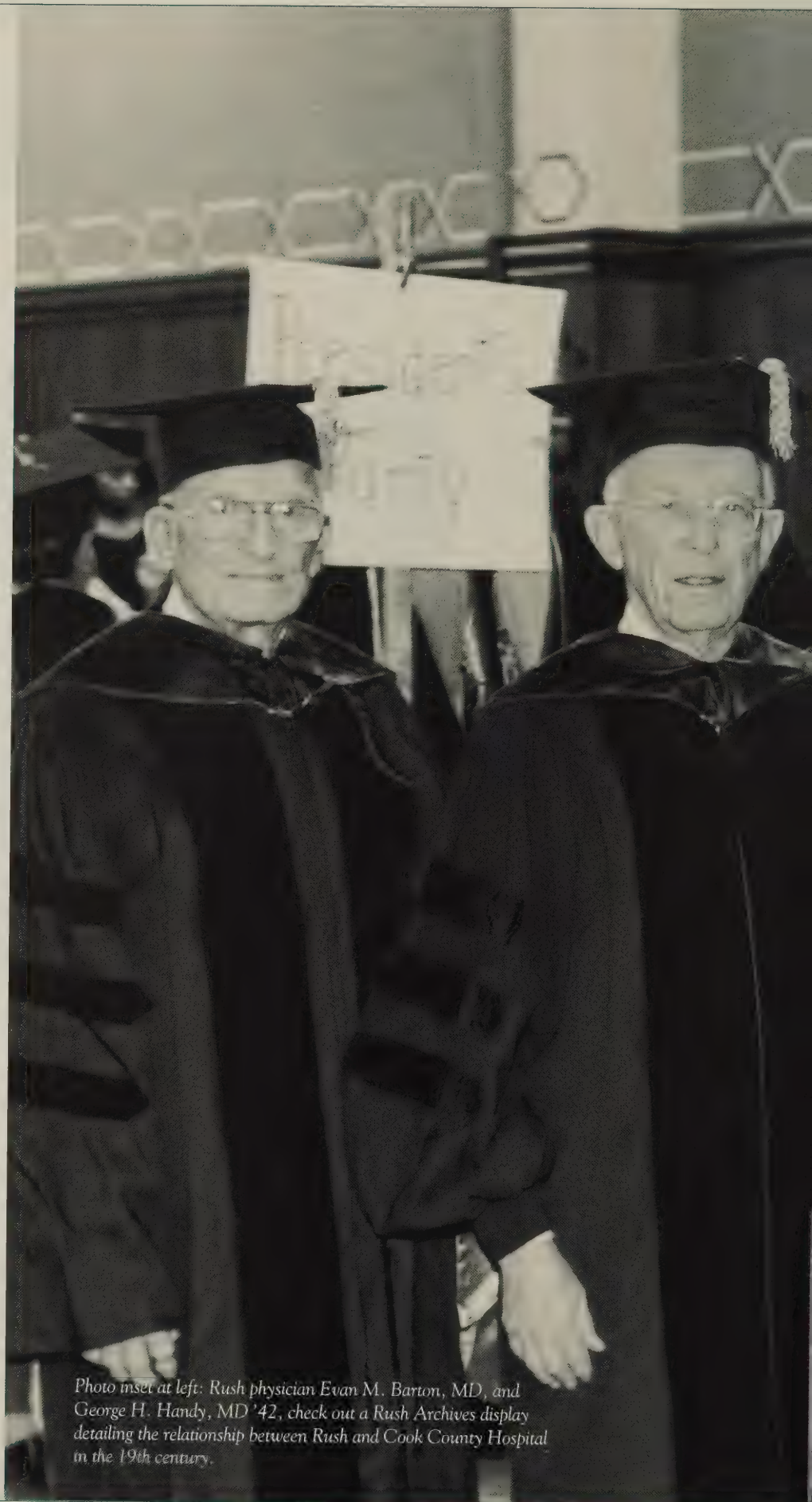


Photo inset at left: Rush physician Evan M. Barton, MD, and George H. Handy, MD '42, check out a Rush Archives display detailing the relationship between Rush and Cook County Hospital in the 19th century.



This page: Wanting a photograph to place in his 1995 Christmas cards, Marshall P. Welles, MD '35 (second from left), asked a few other Rush alumni at commencement to join him in this picture. From left to right: Ralph B. Cloward, MD '35; Welles; Thomas A. Deutsch, MD '79; Richard E. Melcher, MD '75; G. Howard Gottschalk, MD '40; and Harold A. Kessler, MD '74. Gottschalk was named the 1995 Distinguished Alumnus (See page 3).

1995

Alumni WEEKEND

"Alumni Weekend isn't just for alums. Rush medical students attend, too. Students get a chance to learn about the Rush that existed half a century ago and the alums get a chance to hear about the student experience today. It's really a wonderful melding of the different eras."

— Karen B. Weinstein, MD '83
Chairperson, 1995 Reunion
Planning Committee

"I couldn't be more proud to have my son attend the school I graduated from. You only have strong feelings about a few things in life... and when it comes to education, Rush will always stand out in my mind."

— Joseph P. Bernardini, MD '75,
whose son, Brad, is a first-year
Rush medical student.



A Fond Look Back

H. SIDNEY HEERSMA, MD '35, celebrated his 60th class reunion by presenting "A Fond Look Back" for his classmates, alumni and guests at the Dean's Brunch and Annual Meeting. Heersma, a pediatrician, lives in Kalamazoo, Mich.

Borrowing a line from Dickens, Heersma said of the years he attended medical school: "It was the best of times, it was the worst of times." He said 1930 was a good year to enter medicine because the United States had become the new center for study, rather than Vienna, which had held that honor for years.

In those days, students spent the first two years of their medical education

studying at the University of Chicago and the third and fourth years doing clinical work on the west side at Rush.

"The worst of times was that our four years covered the depths of the Great Depression," he said, but added that he was fortunate to live at home in Oak Lawn and drive the 25-minute ride to school in a Maxwell, a car that was popular in the early 1930s.

Heersma shared two stories about the compassion of Rush staff.

"One and a half weeks into the fall semester, I got sick with a fever. I was admitted to Billings Hospital and found to have a right upper lobe pneumonia," he

said. "I ran a 105-degree fever for some days until the crisis came. During that time, Dean Harvey came to visit, which amazed me."

Heersma also talked about his best friend and classmate, Ferdinand "Jake" Jacobson, MD '36, who contracted tuberculosis in his senior year and was confined to Presbyterian Hospital during exam time.

"We had to take nine written and eight oral final exams," said Heersma. "Each of the professors came to his bedside for the orals, and he wrote the writtens at the same time we did."

"Talk about a bedside manner and consideration of the student."

Campbell Winners

RUSH ALUMNI PRESENTED three James A. Campbell, MD, Service Awards at the Dean's Brunch and Annual Meeting. The award—a brass medallion—is bestowed on graduates or friends of the Rush family who show outstanding loyalty and support to the Alumni Association.

Frederic de Peyster, MD '40, listed the positions in the Alumni Association held by

honoree Steven Bines, MD '78. Bines has chaired the reunion planning committee and the class agent network, and he has been the agent for his class since his graduation.

Class of '75 graduate, Joseph Bernardini, MD, presented the next award to his former dean, Leo M. Henikoff, MD, now Rush president and CEO. In his speech, Bernardini described Henikoff as a role model

for commitment, enthusiasm, dedication and perseverance.

The third Campbell award was given by Thomas Deutsch, MD '79, to Vicki J. Woodward, director of the Office of Alumni Relations from 1981 to 1991. Deutsch praised her determination, professionalism, caring spirit and continued support. Since 1991, Woodward has served as the Director of Planned Giving at Rush.

From left: Leo M. Henikoff, MD; Steven Bines, MD '78; Vicki J. Woodward.



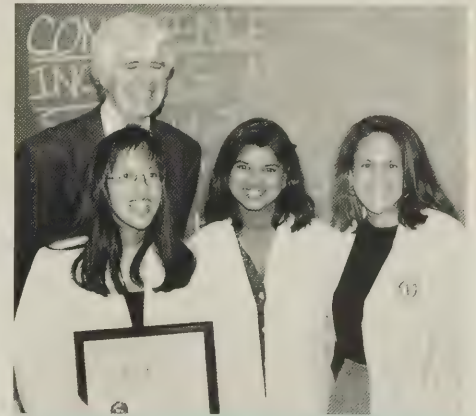
Med Students Display Deductive Skills

A LONG-STANDING FEATURE of the Alumni Reunion Weekend is the Clinicopathological Conference (CPC) at which a group of fourth-year Rush Medical College students, selected by their peers, display their clinical knowledge and deductive skills by diagnosing a particularly tricky patient case.

This year's main presenter was Karen Relucio, now an internal medicine resident at New England Medical Center in Massachusetts. She was assisted by Anila Jonnala, who is currently serving a transitional diagnostic radiology residency, split between West Suburban Hospital in Illinois and the Medical College of Wisconsin, and Lisa Newman, now a family medicine resident at West Suburban Hospital.

The students solved the case of a 50-year-old man who had complained of listlessness, mild anorexia and nausea for more than a year, and showed a pattern of irregular scars on his back. With flawless logic, Relucio deduced the correct diagnosis: an

elusive disease called sarcoidosis, which can cause vague symptoms like those the man reported, and is often characterized by scar tissue on the lungs, liver, skin and other parts of the body.



Front row (l-r), Karen Relucio, Anila Jonnala and Lisa Newman; back row, Alexander Templeton, MD, Professor of Pathology.



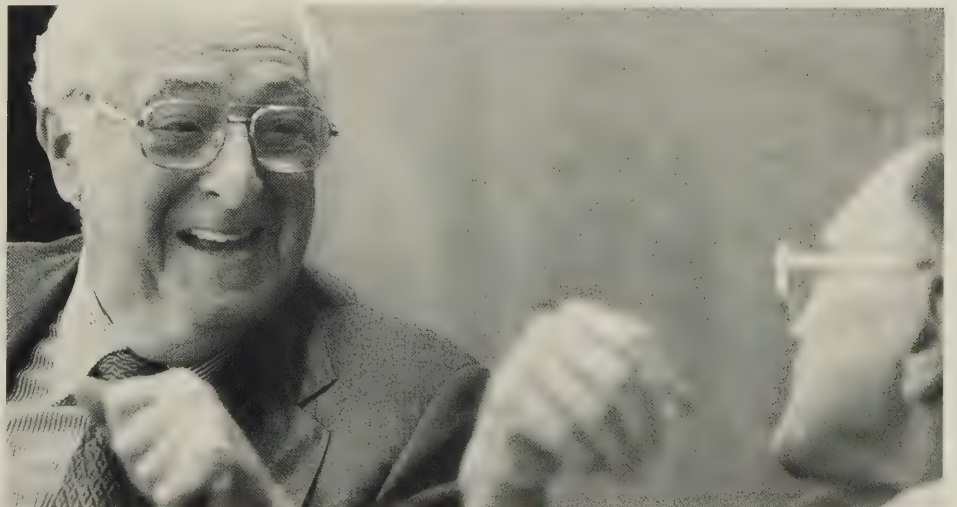
Above: 1980 Rush graduate Barbara B. Loeb, MD, and her daughter, Sarah Rose, get ready to enjoy a luncheon cruise on the Anita Dee II with other Rush alums.

Reminiscing About Rush



Above: 1995 Rush Medical College graduate Marc Breslow at the Commencement Banquet with his guest.

Right: Harold Laufman, MD '37, reminisces with Robert A. Ryan, MD '42.



Bringing Minorities into Medicine

By Erich E. Brueschke, MD, Dean, Rush Medical College



"Set to begin in 1996, (a) six-week program will offer underrepresented minority college students who are interested in becoming physicians the chance to experience science and medicine firsthand."

— Erich E. Brueschke, MD, Dean

ONLY 120 NEW students are accepted into Rush Medical College each year. This group represents some of the nation's most promising future physicians, carefully selected from thousands of applicants.

With a total student population of just 498, Rush remains small, but our reputation is growing. We received a record 5,627 applications for the 1995 entering class, making it the fifth consecutive record-breaking year.

Medical college applications are up nationwide, but the surge at Rush exceeds the national average. We credit this interest to our efforts to expand and enhance Rush's reputation as an innovative school—a school where students like to learn medicine.

A DIVERSE STUDENT POPULATION It has also been our goal to attract more highly qualified underrepresented minority students—and, in a larger sense, to make Rush Medical College a place where diversity can flourish.

Over the past few years, we have stepped up minority student recruitment, and the numbers reflect our efforts. Minority students now make up 9.4 percent of the Medical College student body, compared to 4.3 percent in 1991.

To assure our continued progress, Fred Richardson Jr. MD '87, has been named assistant dean of minority affairs. Fred, who in 1990 completed his residency in the Rush integrated program in family medicine, is highly qualified for this important position. Besides having been an assistant professor at Rush since 1993, he has served as a volunteer mentor for minority students for the past five years.

NEW PROGRAM PROMOTES EARLY RECRUITMENT

Minority student recruitment at Rush will also get a boost from a new summer enrichment program, at four Chicago-area medical schools—Rush, Loyola, Northwestern and the University of Chicago. Set to begin in 1996, the six-week program will offer underrepresented minority college students who are interested in becoming physicians the chance to experience science and medicine firsthand.

The program will be led at all four medical schools by Larry Goodman, MD, associate dean of medical student programs at Rush. It is funded by a \$1 million grant from the Robert Wood Johnson Minority Education Program.

More than 100 minority medical and pre-medical students from throughout the Midwest came to Rush on Nov. 4 to explore the challenges they face in medicine, at the Student National Medical Association (SNMA) Region II Annual Convention. The SNMA is a service organization for minority students involved in the health sciences.

The convention featured two keynote speakers: Kim Joseph, MD, of the Cook County Hospital Department of Trauma Services, who discussed the need to view violence as a healthcare issue, and John Hobbs, MD, of the Rush Department of Obstetrics and Gynecology, who described African-American physicians' role in healthcare reform.

Participants also attended four workshops, two of which addressed controversial issues—primary care versus specialty career choice, and the pros and cons of affirmative action in medicine. The third workshop focused on problem-based learning, and a fourth emphasized procedural skills, as minority physicians from various specialties taught students to perform clinical procedures such as breast exams and lumbar punctures.

Also covered were financial planning and preparation for the match.

"The day was one of the most moving displays of cooperation between minority students at Rush that I have ever seen," says Fred Richardson Jr. MD, assistant dean of minority affairs at Rush, who led the student committee coordinating the event.

Alumni Honor Roll By Class – Fiscal Year

Classes 1930–1933

\$3,953 (12% Participation)

Noah Barysh, MD

Harry B. Miller, MD

* Clarence W. Monroe, MD

* Raymond L. Morris, MD

Tom D. Paul, MD

Donald J. Sabath, MD

Jacob W. Schoolnic, MD

* **Abraham Schultz, MD**

* **Samuel G. Taylor III, MD**

Edward Howard Wagenaar, MD

Class of '34

\$6,100 (20% Participation)

* Edward G. Bourns, MD

Robert D. Fairchild, MD

* Stanton A. Friedberg, MD

Maurice J. Golden, MD

* Vida H. Gordon, MD

* James W. Merricks, MD

Class of '35

\$3,380 (39% Participation)

Herbert C. Breuhaus, MD

Leila Gorenflo Creech, MD

William L. Curtis, MD

A. Stone Freedberg, MD

Alan P. Freedberg, MD

Durward G. Hall, MD

* H. Sidney Heersma, MD

Kate H. Kohn, MD

Lorance T. Krogstad, MD

Wilder P. Montgomery, MD

Arthur M. Olsen, MD

John H. Olwin, MD

Maurice Schneider, MD

Bernadine Siebers-De Valois, MD

Myron F. Sedit, MD

Marshall P. Welles, MD

Class of '36

\$1,170 (30% Participation)

Louis Belinson, MD

Arthur Lawrence Bennett, MD

Harold J. Brumm, MD

Martin Paul Elston, MD

Samuel I. Greenberg, MD

Edwin H. Lennette, MD

Martin Markowitz, MD

Wilfred Lorch Olsen, MD

Abram M. Silvers, MD

Joseph Robert Stone, MD

Jerome H. Tucker, MD

Louis R. Wasserman, MD

Robert G. Weaver, MD

Class of '37

\$4,860 (33% Participation)

William M. Benzing, Jr., MD

Leonard L. Braun, MD

Louis Bush, MD

Lewis Capland, MD

Robert M. Catey, MD

George P. Crillman, MD

Claude R. Davisson, MD

Woodrow Wilson Eddins, MD

Verrill J. Fischer, MD

Walvin R. Giedt, MD

Solomon Barnett Goldman, MD

Bernard Greenberg, MD

Heinz O. E. Hoffmann, MD

Ann Harriet Huizenga, MD

Mayer Hyman, MD

Herman Kirchdoerfer, MD

* **Harold Laufman, MD**

Noah Bernard Levin, MD

Alan A. Lieberman, MD

Emanuel C. Liss, MD

Robert George Mindrup, MD

John A. Nelson, Jr., MD

John Newdorp, MD

* George A. Nicola, MD

Felix Hugh Ocko, MD

Samuel Pollack, MD

Richard Norman Sather, MD

Thomas Andrew Slate, MD

Hugh Henderson Steele, MD

Philip J. Stein, MD

James Stratton, MD

Sidney Trubowitz, MD

* Seymour Weisberg, MD

Class of '38

\$6,205 (50% Participation)

David Leonard Avner, MD

Eugene Joseph Boros, MD

William S. Butts, MD

Gerrit Dangremond, MD

* J. Will Fleming, Jr., MD

Ralph Friedlander, MD

Maxwell H. D. Johnson, MD

Gustav G. Kaufmann, MD

Bernard Martin Kramer, MD

Louis Linn, MD

Selmer Milo Loken, MD

Charles Edgar Magner, MD

Horace D. Mc Gee, MD

Lester Mermell, MD

William H. Orcutt, MD

John D. Porterfield III, MD

Frederick A. Schurmeier, MD

Eric E. Simonson, MD

Fletcher S. Sluder, MD

Rodger Browning Smith, MD

Tetsui Watanabe, MD

* Adolph Weinstock, MD

Class of '39

\$9,480 (28% Participation)

Wilbur G. Braham, MD

* R. Gordon Brown, MD

James Webb Chambers, MD

P. Blair Ellsworth, MD

Robert Brown Henry, MD

H. Kermit Knoch, MD

Allen Rabin, MD

Howard B. Shreves, MD

Thomas W. Sugars, MD

Louis A. Vallecillo, MD

Vern L. Zech, MD

Class of '40

\$6,955 (35% Participation)

E. Gordon Behrents, MD

Clarence Fong Chang, MD

Fred Wylie Clausen, MD

Allan B. Coggeshall, MD

Gordon Hall Congdon, MD

Jackson Culley Dillon, MD

Gene William Farthing, MD

* G. Howard Gottschalk, MD

* Ryland Marcus Jacobus, MD

Edward Lawrence Laden, MD

Eugene Bowles Mc Gregor, MD

Max Benjamin Milberg, MD

Harold F. Schuknecht, MD

Irvin S. Siglin, MD

George W. Smith, Jr., MD

* Roy T. Tanoue, MD

Benjamin Ernest Tuch, MD

Richard C. Vanderhoof, MD

John A. Watson, MD

Class of '41

\$1,620 (46% Participation)

Shoichi Asahina, MD

Harold A. Bjork, MD

John McKeil Bowen, MD

Irving Eugene Brown, Jr., MD

Joseph J. Eckert, MD

William R. Garr, MD

Ralph Duane Good, MD

Charles M. Grace, MD

Aaron Grossman, MD

Alexander Hilkevitch, MD

Alfred P. Kraus, MD

Loren Joseph Larsen, MD

Ralph Siler Morgan, MD

John William Pace, MD

Leibert J. Sandars, MD

Nathan Shlim, MD

Eben Stoddard, MD

Blake S. Talbot, MD

John W. Wichman, MD

John Guinan Wilcox, MD

Vinton Hodge Wright, MD

Class of '42

\$7,070 (51% Participation)

Carl P. Adatto, MD

Donald Leo Alcott, MD

William F. Bethard, MD

Andrew Kimmins Butler, MD

Robert Anderson Crawford, MD

Joseph T. Crockett, MD

Harold E. De Pree, MD

Charles F. Downing, MD

Thomas C. Glasscock, MD

Russell Lawrence Hafer, MD

Edward Jordan Hagan, MD

* **George H. Handy, MD**

Helen Jane Hare, MD

* Kenneth T. Hubbard, MD

Royal Ernest Ihrke, MD

Frank Waters Johnson, MD

Nathan Hall Mahon, MD

Hugh Alexander Mc Intosh, MD

Isaac Eldrew Michael, MD

Milton E. Nugent, MD

* **Robert A. Ryan, MD**

Edward William Schlies, MD

Eugene J. Usow, MD

Jerome Waldman, MD

Frederick S. Webster, MD

Elsie Winchester, MD

William W. Winchester, MD

* Member of Benjamin Rush Society

Bold denotes leadership volunteer

Class of '73

\$8,325 (32% Participation)
 Alan B. Bergman, MD
 Joseph D. Billotti, MD, P.A.
 Michael J. Cwynar, MD
 * Mark Lurie, MD
 * **Marvin B. Padnick, MD**
 * Ronald W. Quenzer, MD
 Floyd F. Shewmake, Jr., MD
 * Gary J. Snyder, MD
 Glen E. Sutherland, MD
 * Edward J. Weiner, MD
 Byron G. Young, MD

Class of '74

\$11,525 (29% Participation)
 * Anne Salmon Barone, MD, Ph.D.
 * Tina M. H. Blair, MD
 * **Willie C. Blair, MD**
 * Ruth S. Campanella, MD
 Ephraim S. Casper, MD
 Donald J. Corey, MD
Howard Derman, MD
 Donald B. Fletcher, MD
 * John J. Garvie, MD
 Richard W. Hart, MD
 * **Harold A. Kessler, MD**
 Lawrence F. Layfer, MD
 Frank C. Madda, MD
 * **Walter E. Meyer III, MD**
 Stephen Paul Montgomery, MD
 Stephen Mueller, MD
 * **Ronald D. Nelson, MD**
 Jack C. Nichols II, MD
 Michael R. Peck, MD
 John R. Schmitt, MD
 Alain J. Tylon, MD
 Larry Wilcken, MD

Class of '75

\$22,310 (41% Participation)
 * **Joseph P. Bernardini, MD**
 Richard H. Bien, MD
 Robert Cairns, MD
 Jacques M. Calma, MD
 * Robert Lee Cavens, MD
 Robert L. Cohen, MD
 * Dino S. Delicata, MD
 Gordon H. Derman, MD
 Robert N. Dunn, MD
 William Dwyer, MD
 Martin Faber, MD
 * **Glen O. Gabbard, MD**
 * **Steven Gitelis, MD**
 Christopher G. Goetz, MD
 Henry M. Gold, MD

Michael Gold, MD
 William F. Graettinger, MD
 * Daniel J. Hennessy, MD
 Stephen R. Humowiecki, MD
 * Michael L. Hundert, MD
 Jeffrey R. Kanofsky, MD
 * Jeffrey C. King, MD
 John Kowalski, MD
 * **Richard E. Melcher, MD**
 Kenneth A. Miller, MD
 * David F. Morgan, MD
 Mark A. Moyer, MD
 Stephen J. Playe, MD
 John Rankin, MD
 Kim G. Rothermel, MD
 Steven Rottman, MD
 Harold A. Sand, MD
 * Anthony W. Savino, MD
 Bruce F. Schilt, MD
 * Kenneth S. Shapiro, MD
 Charles Sheaff, MD
Steven E. Sicher, MD
 * Paul H. Werner, MD

Class of '76

\$6,450 (23% Participation)
 * **Henry I. Danko, MD**
 Melody Cobleigh, MD
 * **Barbara Fuller, MD**
 John E. Gocke, MD
 Andrea L. Hedin, MD
 * Robert N. Jones, MD
 Howard W. Needelman, MD
 Mark A. Patterson, MD
 Betsy J. Pepper, MD
 * Beatrice L. Pitcher, MD
 Martin G. Siglin, MD
 Bertram Spetzler, MD
 Stanley Whittemore, MD
 Alan Wright, MD

Class of '77

\$6,245 (38% Participation)
 Janice B. Asher, MD
 Thomas P. Bleck, MD
 Michael Blefeld, MD
 Ernest Dale Buck, MD
 Ann M. Buettner Glass, MD
 Charles Stewart Colodny, MD
 Steven M. Croft, MD
 Gary Michael Deutsch, MD
 Richard L. Ellis, MD
Max L. Harris, MD
 Martin Hickey, MD
 W. Andrew Hodge, MD
 Lawrence Joseph Kohaus, MD

Carol Laderman, MD
 Marc Lorber, MD
 Robert J. Marder, MD
 David I. Margolin, MD
 Richard A. Menet, MD
 Gregory J. Mertz, MD
 Robert F. Mulch, Jr., MD
 James White Murphy, MD
 Timothy C. Payne, MD
 Donna Rabin, MD
 Warren Steven Richardson, MD
 Arnold Robin, MD
 Richard Shapiro, MD
 Renslow Drew Sherer, Jr., MD
 Gary Sherp, MD
 Daniel Jay Smith, MD
 David Stair, MD
 James Edward Swanson, MD
 Stephen Tarzynski, MD
 * April H. Teitelbaum, MD
 Mary C. Tobin, MD
 Michael R. Zile, MD

Class of '78

\$11,905 (31% Participation)
 Alpheu T. Appenheimer, MD
 Frederick B. Bustin, MD
 Pamela Charney, MD
 Diane Gomez Dahmer, MD
 Richard Drimalla, MD
 * John C. Farrin, MD, J.D.
 Nathaniel Fastenberg, MD
 * **Kim M. Fehir, MD, Ph.D.**
 Allen D. Korenblit, MD
 Elliott Kroger, MD
 Jeffrey Lazarus, MD
 Patrick J. Loehrer, MD
 Richard Lozoff, MD
 * John W. Mc Clean, MD
 Rick A. Nishimura, MD
 Mary K. Palmore, MD
 Timothy Pohlman, MD
 * Arvin Raheja, MD
 David O. Ranz, MD
 Kenneth R. Roepke, MD
 * Robert Rotering, MD
 Steven K. Sauerberg, MD
 Shannon J. Scarry, MD
 James A. Simon, MD
 Donald A. Skor, MD
 Robert W. Stein, MD
 Dennis Swenie, MD
 Babs Waldman, MD
 Myron Wojtowycz, MD
 * Fuk Chun Alan Wong, MD
 Donald V. Woznica, MD

Class of '79

\$6,715 (23% Participation)
 * Phyllis C. Bleck, MD
 Denis F. Branson, MD
 * Steven V.L. Brown, MD
 Joseph R. Cline, MD
 Michael Kane Cochran, MD
James J. Collins, MD
 * **Thomas A. Deutsch, MD**
 Jacques N. Farkas, MD
 Judith Feinberg, MD
 Mary Ellen Gruszka, MD
 Irene R. Japha, MD
 Judd M. Jensen, MD
 Richard A. Kaplan, MD
 Stephen M. Korbet, MD
 Peter Sundehl Krogh III, MD
 John Francis Neylan III, MD
 Douglas O. Olsen, MD
 Lance A. Pickrell, MD
 John P. Quinn, MD
 Marjorie Mintz Rosenbaum, MD
 David C. Schewitz, MD
 Michael D. Schreiber, MD
 Susan Taich Schufeldt, MD
 Walter Siller, MD
 Michael C. Smith, MD
 Aimee C. St. Pierre, MD
 Jan O. Stampley, MD
 Elizabeth M. Stone, MD
 Mary Lou Tomyanovich, MD
 James M. Torres, MD
 John F. Tucker, MD
 Derek Van Amerongen, MD
 Linda Wagner-Weiner, MD
 Ronald L. Weinstein, MD

TOP 10 CLASSES by Dollars Donated

Rank	Year	Amount
1	1975	\$22,310
2	1980	\$14,150
3	1978	\$11,905
4	1974	\$11,525
5	1981	\$10,000
6	1939	\$ 9,480
7	1973	\$ 8,325
8	1942	\$ 7,070
9	1940	\$ 6,955
10	1979	\$ 6,715

Class of '80

\$14,150 (34% Participation)

Allen R. Braun, MD
Charlotte S. Brody, MD
Bruce H. Campbell, MD
Mary Therese Cunnane, MD
Mary Barton Durfee, MD
Neal D. Epstein, MD
Randy J. Epstein, MD
James W. Faulkner III, MD
Mary Rascia Forman, MD
Martin G. Fortier, MD
* Julie Ann Freischlag, MD
Jack Fuhrer, MD
Robert G. Gillio, MD
* **Catherine Grotelueschen, MD**
Richard G. Hayes, MD
Jean L. Holley, MD
* Keith D. Jorgensen, MD
Carol Krohm, MD
Andrea L. Lawless, MD
Michael A. Laws, MD
* **Jay L. Levin, MD**
Barbara B. Loeb, MD
Susan T. Lyon, MD
Phillip J. Maple, MD
* Wayne S. Margolis, MD
Sara Gottlieb Monroe, MD
James E. Moyer, MD
Steven M. Mulawka, MD
Richard S. Murray, MD
Patricia M. Picchetti, MD
Gregory W. Schroff, MD
Neil David Smith, MD
Demetra K. Soter, MD
Andrew F. Stasic, MD
Rhonda E. Stein, MD
Angela G. Stewart, MD
* Jonathan B. Stout, MD
Daniel J. Sullivan, MD, J.D.
Robert W. Trauscht, MD
Elizabeth H. Waldron, MD
Peggy E. Warren, MD
Peter C. Witt, MD
Leslie T. Yamamoto Purtell, MD

Class of '81

\$10,000 (25% Participation)

Oscar L. Alonso, MD
Randy Andrews, MD
Camilla Ashley, MD
David Baldwin, Jr., MD
Thomas R. Bardolph, MD
Elbert C. Collins, MD
Robert L. Conter II, MD
Ethan H. Daniels, MD

Karen L. Dedman, MD
Tasia Economou, MD
Dale H. Foster, MD
Scott Ghinazzi, MD
John Hamby, MD
* David W. Hines, Jr., MD
Camille Y. Honesty, MD
Daniel R. Jarzemsky, MD
Linda R. Kaplan, MD
Amelia H. Kaymen, MD
Steven H. Khan, MD
Steven A. Kooperman, MD

* Judith A. Kooser, MD
Man H. Lee, MD
Thomas E. Liao, MD
Sarah Tucker Lincoln, MD
Eric Lyerla, MD
* Stavros N. Maltezos, MD
* James E. Memmen, MD
Diane Di Maggio Nissen, MD
Richard M. Novak, MD
Lin Elizabeth Roberts, MD
Robert Sbriglio, MD
Richard W. Schifeling, MD
Fred M. Volkman, MD
Susan M. Weisberg, MD
Jeffrey Wishik, MD

Class of '82

\$3,720 (24% Participation)

Stephen F. Bansberg, MD
Scott C. Berman, MD
* Paul R. Blattberg, MD
Pamela J. Clair, MD
Ani B. Darakjian, MD
Marguerite R. Dillaway, MD
John S. Dimant, MD
Andrew Dale Edwards, MD
John D. Edwards, MD
Michael Feltes, MD
Jeffrey A. Goodman, MD
Barbara J. Green, MD
Mary Hagerty, MD
Dennis Miller, MD
Cynthia R. Morgan, MD
Ira M. Nathanson, MD
Thomas H. Noller, MD
Richard J. Pawl, MD
Thomas M. Pellino, MD
Warren D. Robinson, MD
Paul J. Schmidt, MD
Manojkumar Shah, MD
Bruce Samuel Shames, MD
Greg E. Sharon, MD
David A. Stewart, MD
Phillip E. Styka, MD

Daniel Yohanna, MD
Dorothy Ann Zielinski, MD

Class of '83

\$4,890 (27% Participation)

Lawrence A. Albani, MD
Barry H. Bikshorn, MD
James F. Blechl, MD
Robert W. Bloom, MD
Kevin Conlon, MD
Christine Darr, MD
Mark Davis, MD
Alison J. Drumm, MD
Janis Enzenbacher, MD
Randall J. Gordon, MD
Cynthia Hahn, MD
C. Grafford Hilgenhurst, MD
Marcia A. Johnson, MD
* **Paul J. Jones, MD**
Gary L. Koehn, MD, Ph.D.
Lisbeth M. Lazon, MD
Truong-Sinh Leduc, MD
Curt E. Liebman, MD
George Marosan, MD
James W. Mitchell, MD
Kathryn H. Mulligan, MD
John E. Nelson, MD
Bryan P. Pechous, MD
Ronald Pepitone, MD
Angela R. Perry, MD
Jose R. Quero, MD
Glenn D. Sakamoto, MD
Michael Warren Schwartz, MD
Sanford S. Sherman, MD
Erik Stabell, MD
Kristen M. Stabell, MD
Jonathan R. Starr, MD
Danny H. Sugimoto, MD
Sondra Summers, MD
Kevin P. Sweeney, MD
Ellen Tabor, MD
Henry D. Tazelaar, MD
John Timmons, MD
Charles Tomaszewski, MD
* **Karen B. Weinstein, MD**
Mark D. Wittry, MD

Class of '84

\$2,385 (22% Participation)

David A. Bennett, MD
Kenneth J. Bloom, MD
Thomas H. Burnstine, MD
Linda T. Brubaker, MD
Larry D. Cripe, MD
Sharon Thomas Flint, MD
Sally Belcove Frankl, MD

James A. Froehlich, MD
Mary K. Haag, MD
Brian D. Haas, MD
Ronald Haberman, MD
James A. Hunter III, MD
Valerie Y. Ito, MD
Arthur Dean Jabs, Jr., MD, Ph.D.
Sushil V. Karmarkar, MD
Mary Ann Kenny, MD
Ilan Kinori, MD
David A. Ladden, MD
David L. Lemak, MD
Mary Beth Leonard, MD
Mark Litchman, MD
Marian Macsai-Kaplan, MD
Thomas J. Nielsen, MD
Crystal Hedgl Peoples, MD
Eugene P. Podrazik, MD
Mary-Louise Scully, MD
James Adam Shapiro, MD
Michael A. Skinner, MD
Robert Jeffrey Snell, MD
Timothy W. Starck, MD
Ronald H. Stefani, Jr., MD
Jeffrey D. Tiemstra, MD
Peter B. Wilson, MD
Martin J. Yee, MD
Bonnie Todd Zima, MD
Ralph J. Zitnik, MD

* Member of Benjamin Rush Society
Bold denotes leadership volunteer

TOP 10 CLASSES by Percent Participation

Rank	Year	% of Class
1	1942	51%
2	1938	50%
3	1941	46%
4	1975	41%
5	1935	39%
6	1977	38%
7	1940	35%
8	1937	33%
9	1978	31%
10	1985 and 1930	30%

Class of '85

\$5,605 (30% Participation)

Richard M. Baley, MD
Donna M. Bicknese, MD
Jai H. Cho, MD
Dean J. Conterato, MD
Barbara A. Dappert, MD
Judy Dunal, MD
Carole R. Dunmire, MD
Robert W. Frederick, MD
Ellen J. Glick, MD
Diane P. Gruber, MD
David P. Hejna, MD
Betty Hsia, MD
Bradley Hubbard, MD
* Ned R. Jacobson, MD
Patrick G. Kirk, MD
Nicki E. Lekas, MD
Amy Light, MD
Charles R. Lindley, MD
Shari Ludwig, MD
Joan Lynch, MD
Rosemary Mc Grath, MD
Elizabeth L. Nye, MD
Nina A. Paleologos, MD
Scott B. Palmer, MD
Stephen Paul, MD
Antoinette G. Quigley, MD
Ellen B. Rest, MD
Susan A. Roth, MD
Jeffery S. Royce, MD
Kathryn Schutt-Kinnear, MD
David Simon, MD, Ph.D.
Stephen M. Smith, MD
Wendy Stock, MD
John-Peter Temple, MD
Fred J. Turner, MD
Rebecca Unger, MD
Michael L. Waszak, MD
Eric Yokoo, MD
Michael Jay Young, MD

Class of '86

\$2,370 (21% Participation)

Janis Marie Atkinson, MD
Lauren Beth Baker, MD
Lesley Brinkman-Mosiman, MD
Kersti M. K. Bruining, MD
Aaron Joseph Chun, MD
Joseph L. D'Silva, MD
Nancy Kathleen Deaton, MD
Elizabeth A. Frederick, MD
Jill Maitland Gotoff, MD
Robert A. Gottoff, MD
Nina Louise Gotteiner, MD
Susan L. Haverstock, MD

Todd J. Janus, Ph.D., MD
W. Scott Jellish, MD, Ph.D.
Kimball Ladien, MD
Sanford Lorin Lapin, MD
Derek J. Li, MD
Jeffrey Scott Meisles, MD
Martha Louise Millar, MD
Timothy J. Morton, MD
Michael Thomas Nathan, MD
John Norton, MD
David Wayne Ozinga, MD
Robert A. Petersen, MD
Anna Marie Poulos, MD
Keith Michael Rezin, MD
John Jay Shannon, MD
Mark Alan Simaga, MD
Stuart Ray Verseman, MD
Mary Ellen Walsh, MD

Class of '87

\$1,790 (22% Participation)

Jane Ellen Billeter, MD
Daniel J. Brugioni, MD
Jack Victor Carlisle, MD
Robert Paul Chayer, MD
Jonathan Samuel Cohen, MD
Pamela M. Donlan, MD
Paul K. Feldman, MD
Beth Ginsburg, MD
Cynthia Lauren Gould, MD
Diane S. Jundanian, MD
Paul Anthony Karazija, MD
Helen R. Minciotti Koehler, MD
Janice Krakora-Looby, MD
Paul Evans Later, MD
Kathryn Ann Lemmerman, MD
Jeffrey M. Lisowski, MD
Steven Mark Malkin, MD
Timothy Erin Napier, MD
Thomas Ying Chung Pang, MD
Nicholas G. Recchia, MD
Maureen Seeley Richards, MD
Laura Steffen Tanner, MD
Neil Jay Thomas, MD
Gary Edward Waters, MD
Susan Wilcoski, MD
Steven Clement Yuill, MD

Class of '88

\$980 (18% Participation)

Jeffrey B. Asbury, MD
Michael J. Barkoviak, MD
Anthony Joseph Bell, MD
Patrick L. Blohm, MD
Donald Scot Childs, MD
Gregory Edmund Chow, MD

Michael Edward Cucka, MD
Dean A. Delmastro, MD
Todd Richard Ewert, MD
Polina T. Feygin, MD
Gregory Lewis Hazle, MD
Maureen Shea Holland, MD
Louise Berner-Holmberg, MD
Richard Jay Katz, MD
Gary Alan Kaufman, MD
Keith Y. Kohatsu, MD
* Mark N. Levin, MD
Steven Lee Meyers, MD
Aubrey Keith Miller, MD, M.P.H.
Ivan Mark Pavkovic, MD
David Joseph Powers, MD
John Mark Revis, MD
James Joseph Rydel, MD
Michael D. Van Anrooy, MD
Cynthia Marie Waickus, MD
Valerie Walker, MD

Class of '89

\$1,440 (17% Participation)

Martin James Caliendo, MD
Melanie Anne Cerinich, MD
Gregory Aaron Cohen, MD
Laurie Ann Dimaria, MD
Salvador Gutierrez, MD
Jean M. Houlihan, MD
Ian Jasenof, MD
Michael Martirano, Jr., MD
Mary L. Mc Comis, MD
Diane Louise Mueller, MD
Shammai Rockove, MD
Domenica Marie Rubino, MD
Roger C. Scholten, MD
Thomas Dean Stamos, MD
Amy Louise Stoeffler, MD
Maria V. Swastek, MD
Elizabeth Ann Wetzel, MD
Anne Lyall Wyman, MD
Sara Ann Zibert, MD

Class of '90

\$765 (21% Participation)

Karen Balzanto, MD
Andrew James Boshardy, MD
Kathryn A. Collins, MD
Jeffrey C. Cooper, MD
Marion Couch, MD, Ph.D.
Peter DeGolia, MD
James Newell Dillard, MD
Pezhman Ebrahimzadeh, MD
Terrence P. Gleason, MD
Andrea Gonzalez-Stampley, MD
Rena Goodfriend-Leve, MD

Ommar Hla, MD
Rahul Navin Joshi, MD
Kipp Kennedy, MD
Robert G. Kummerer, MD
Claudia F. Lucchinetti, MD
Sheila M. Major, MD
Allison E. Murchison, MD
Michael J. Paveloff, MD
Michael C. Preys, MD
Jordan Pritikin, MD
Linda M. Razabdouski, MD
Marc C. Sandrolini, MD
Madelyn C. Sieraski, MD
Nicholas J. Speziale, MD
Glenn Allan Weiss, MD
David Yeung, MD
Neringa Z. Zadeikis, MD

Class of '91

\$375 (15% Participation)

Benjamin T. Agana, Jr., MD
Peter J. Egofskes, MD
Jennifer J. England, MD
Jerome J. Hannigan, MD
Vanessa M. Hart, MD
Ryon Michael Hennessy, MD
Anthony Kwan, MD
Kevin Maquiling, MD
Sandy S. Mc Gaffigan, MD
Daniel James Pohlman, MD
Michael Jay Rosen, MD
Geoffrey R. Sebastian, MD
Gayathri Sundaresan, MD
Paul R. Swoboda, MD
Cindy Lou Tamminga, MD
Paul Arne Walker, MD

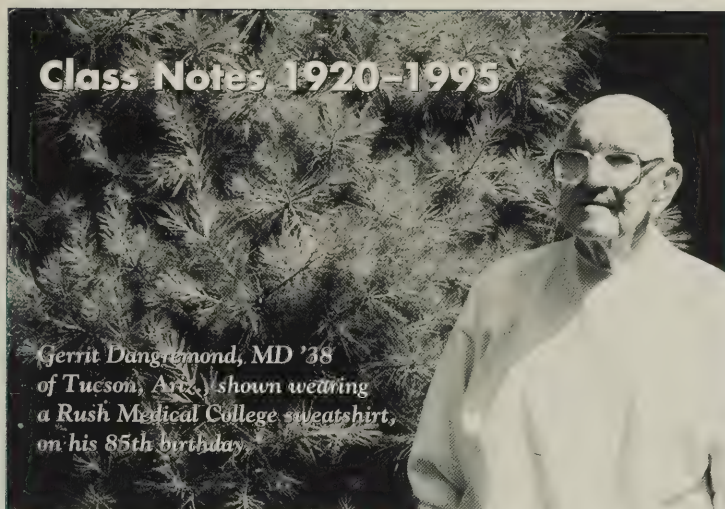
Classes 1992-1994

\$425 (4% Participation)

Susan Cash, MD
Gonzalo D. Castillo, Jr., MD
Michael John Costello, MD
Roy G. Eenigenburg, Jr., MD
Deborah Anne Gottmann, MD
Sunanda V. Kane, MD
Teri Ann Kyrouac, MD
Joseph Kowalczyk, MD
Alan Matson, MD
Liza Pilch, MD
Ligia Neida Rioja, MD
Desiree Soter-Pearsall, MD

* Member of Benjamin Rush Society
Bold denotes leadership volunteer

Class Notes 1920-1995



Gerrit Dangremond, MD '38 of Tucson, Ariz., shown wearing a Rush Medical College sweatshirt, on his 85th birthday.

1920s

ESTHER SOMERFELD-ZISKIND, MD '24, of Los Angeles, Calif., recently celebrated her 94th birthday with her daughter, grandson, great grandson and other family members. She still sees patients, without fee, under a special state license for retired physicians. Dr. Ziskind also frequently attends lectures at Cedars Sinai and Children's Hospitals, is active on many committees, writes book reviews, and enjoys playing the piano—all from a wheelchair.

1930s

NATHANIEL E. REICH, MD '32, of Brooklyn, N.Y., has given lectures and had adventures on six continents, and met a dozen heads of state and tribal chiefs. He has written a book, *A Renaissance Man at Large* (Riverview Publishing Co.) and a book of poetry.

ALLAN A. FILEK, MD '33, of Sun City, Ariz., still works one day a week at Western Plasma Products in Phoenix. He has two great grandchildren.

CLARENCE WEBSTER MONROE, MD '33, of Waverly, Ohio, married Mary Elizabeth McClanahan Turnbull on January 14, 1995. "No gifts, PLEASE!" read their announcement. "We are struggling to put in one house the accumulation of 112 years of married life."

Thanks to a recent lumbar disc removal, WILLIAM L. CURTIS, MD '35, of Mercer Island, Wash., is out of his wheelchair and back into activities.

H. STANLEY HEERSMA, MD '35, of Kalamazoo, Mich., was recently named one of 17 outstanding Michigan physicians by the Michigan State Medical Society. Dr. Heersma received a community service award from the society in March, acknowledging his 58 years of pediatric care to the children of Kalamazoo. (Dr. Heersma recalls his days as a student in "A Fond Look Back," page 6).

LOUIS BELINSON, MD '36, retired in 1971 and has lived in Key Largo, Fla., since 1973.

CHARLES EUGENE MUHLEMAN, MD '37, of LaPorte, Ind., enjoys retirement somewhat, but misses his practice in pediatrics and allergy, which he maintained until

1989. His wife, Marjorie Keil Muhleman, RN, Pres. '33, died in 1989. "Friends keep me busy," he writes.

FREDERICK SCHURMEIER, MD '38, of Elgin, Ill., retired from general practice in 1978. He and his wife, Norma, divide their time between Green Valley, Ariz., and Elgin. "Time has dealt kindly with me, and I still play a little golf in Arizona," writes Dr. Schurmeier. He played clarinet in the Elgin Symphony Orchestra for 21 years.

JAMES W. CHAMBERS, MD '39, of Des Moines, Iowa, retired in June 1990 after 50 years in mostly solo practice of internal medicine in Des Moines.

1940s

G. HOWARD GOTTSCHALK, MD '40, of Los Angeles, Calif., is semi-retired, working two half days a week. He keeps out of mischief by playing golf and traveling. Dr. Gottschalk is the 1995 Rush Medical College Distinguished Alumnus (see story, page 3).

ROBERT E. KIRKMAN (Formerly Kirschman), MD '42, of Key Biscayne, Fla., will retire in 1996, but for now he still practices in Miami—mostly rhinoplasty. He also scuba dives, skis, plays tennis, and plays the violin in a local symphony. He lost his wife, Eleanor, four years ago. "Visitors are welcome," he writes.

EUGENE J. USOW, MD '42, of Laguna Hills, Calif., reports that his grandson thoroughly enjoyed the month he recently spent at Rush, as part of his senior-year studies at Tulane.

1970s

JEFFREY D. FELDSTEIN, MD '73, has moved to Scottsdale, Ariz. He now practices full time in Glendale and plans to reacquaint himself with MARVIN B. PADNICK, MD '73, who lives in Phoenix.

STEPHEN R. HUMOWIECKI, MD '75, of Oak Park, Ill., writes that 1995 is a better year—he now has only two children in college. His eldest, Mark, graduated from Yale in 1994 and is teaching in a private middle school in Harlem. His second son, Joel, is at Loyola, ("studying basketball, most of all," says Stephen). His daughter, Amy, has finished her second year at University of Michigan and his wife, Judy, is completing a three-year program at Lutheran General in pastoral psychotherapy. The Wholistic Health Center of Oak Park, which Stephen heads, is now 17 years old.

After 15 years in Washington at Georgetown, JEFFREY C. KING, MD '75, has moved to Dayton, Ohio, to become professor of obstetrics and gynecology, and director of the division of maternal-fetal medicine at Wright State University School of Medicine. Georgetown University's Department of Obstetrics and Gynecology honored King earlier in 1995 as "Academic Teacher of the Year." "Drop in if you are ever in town," he writes.

"Things are going great," writes KIM M. FEHIR, MD '78, of Houston, Texas. "My husband and I are partners in a snowshoe business, Yuba Shoes ... Lots of fur."

ELLIOTT KROGER, MD '78, of Oak Park, Ill., is an internist on

staff at West Suburban Hospital Medical Center in Oak Park.

TIMOTHY LLOYD BURKE, MD '79, of Superior Wis., has joined the Duluth Clinic and is practicing primary care in Superior. From 1987-1994, he had a solo practice in infectious diseases in Traverse City, Mich.

BRADFORD C. ROBERG, MD '79, who is a plastic surgeon on staff at Good Shepherd Hospital in Barrington, Ill., was recently elected a member of the American Association for Hand Surgery.

1980s

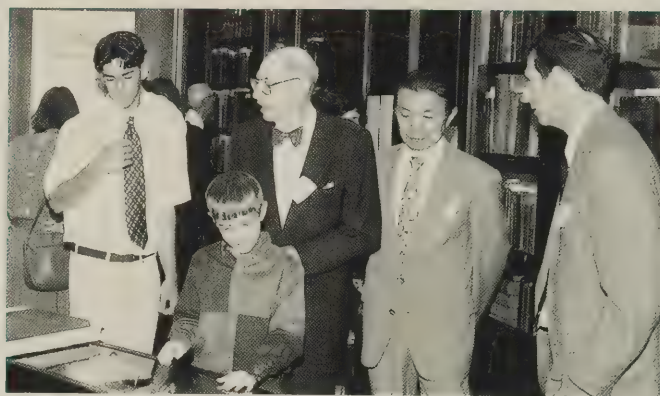
JAMES F. BLECHL, MD '83, of Granger, Ind., is in private practice in South Bend. He is also part of a group of family doctors involved in medical missions.

DAVID B. TICK, MD '83, of Mequon, Wis., is currently an assistant professor of pediatrics, internal medicine and pathology—specializing in medical genetics, clinical dysmorphology, and inborn errors of metabolism—at the Medical College of Wisconsin in Milwaukee. He is about to venture into private practice.

RONALD J. HABERMAN, MD '84, of Scottsdale, Ariz., has been in solo practice since May 1994 in Scottsdale. His practice is limited to cardiac electrophysiology.

KEVIN W. LUKE, MD '84, of Darien, Ill., has joined the medical staff of Palos Community Hospital in Palos Heights, Ill.

JAMES M. NOSAL, MD '84, recently moved to Sun Prairie, Wis., from Rockford, Ill. He now works for Dean Clinic and is enjoying his free time with



THE STANTON A. FRIEDBERG, MD, RARE BOOK ROOM of the Rush University Library was formally dedicated and named July 18. Dr. Friedberg, a member of the Class of '34 who has served on the Rush medical staff for 58 years, has devoted years to collecting and cataloging many of the rare historical books that make up the library's collection. Philanthropic gifts from Dr. Friedberg, and his family, friends, colleagues and fellow alumni were used to establish an endowment to support a curator for the room's treasures.

wife, Jane, and daughters, Amy, 6, and Caroline, 4.

BARBARA DAPPERT, MD '85, of Wexford, Pa., is a neurologist involved in private practice and teaching. Interests include tennis and photography, "but mostly the joy of our two girls, ages 1½ and 4 years," Barbara writes.

MATTHEW BOENTE, MD '86, has joined the department of gynecologic oncology at Paoli Memorial Hospital in Wayne, Pa.

DAVID N. MOWBRAY, MD '86, of Scottsdale, Ariz., has started a new solo practice in dermatology, with emphasis on cosmetic laser procedures and hair transplants.

LOUIS CIACCIA MONTANA, MD '87, of Chicago, has joined the medical staff of Central DuPage Hospital in Winfield, Ill. A board-certified surgeon, Louis practices in Winfield and Naperville.

JEFFREY B. ASBURY, MD '88, of Chicago, will soon complete his urology residency at Loyola University Medical Center in Maywood, Ill., and begin private practice at MacNeal Hospital in Berwyn, Ill.

DONALD S. CHILDS, MD '88, of Forest Park, Ill., and his wife, Karen, gave birth to Anne Elizabeth on April 25, 1995. She joins Megan, 5, Abigail, 3½, and Donald, 19 months.

RONALD S. STUMBRIS, MD '88, recently opened a practice in primary care in Oregon, Ill.

MARK S. DWORKIN, MD '89, of Kirkland, Wash., is an epidemic intelligence service officer for the National Centers for Disease Control and is stationed at the Washington Department of Health in Seattle.

MARTIN JOSEPH GADEK, MD '89, of Rochester, Minn., has joined the staff of Memorial Hospital in Burlington, Wis.

1990s

OSAMA K. ATIEH, MD '90, of Oak Lawn, Ill., has joined the medical staff of Christ Hospital and Medical Center in Oak Lawn. He is a practicing internist.

CHARLES J. KUCERA, MD '90, of Hudson, N.Y., is a board-certified family practice physician in upstate New York. He is working to expand HIV/AIDS education in the community and to increase access to care for people with HIV infection and AIDS.

ANTHONY A. NAZAROFF, MD '90, and his wife, Anne, are the proud parents of Sonia, born November 16, 1994. Tony, who lives in Temple, Texas, is finishing the last year of a urology residency at Scott and White Hospital and Clinic.

JEFFREY MARK SMITH, MD '90, of Germantown, Tenn., and his wife, Shannon, became the proud parents of Ryan Alexander Smith on July 31, 1993. This June, he completed his orthopedic residency at the University of Tennessee's Campbell Clinic. In July, he started a fellowship at the Sunnybrook Health Science Centre of Toronto, Canada, where he will study joint reconstruction surgery and trauma.

BENJAMIN T. AGANA, MD '91, of Dallas, Texas, completed a residency at Baylor College of Medicine in Houston and joined a private practice group in Dallas.

MELISSA MILLER HUTCHISON, MD '91, of Prospect, Ohio, is finally out in the real world, working in a busy family practice in Prospect, just north of Columbus. Attending a

CME conference at Johns Hopkins earlier this year, Melissa met up with fellow alternative curriculum alums ROBERT Mc CARTHY, MD '91 and SUE BARDWELL, MD '92. "Ron and I are busy with Colin, age 2½, two VW buses, and one on the way—a baby, not a bus!" she writes.

TIMOTHY JAMES RUETTEN, MD '91, of Peoria, Ill., has joined Kishwaukee Medical Associates in Sycamore, Ill. He is a family practice physician.

GEOFFREY SEBASTIAN, MD '91, of Elmhurst, Ill., was appointed to a one-year position as chief resident for the

transitional medicine residency program at MacNeal Hospital in Berwyn, Ill. He completed a primary care/internal medicine residency at Loyola University Medical Center in Maywood, Ill., in June.

RANDALL W. PORTER, MD '93, of Phoenix, Ariz., and his

wife, Brooke, have two children—Christine, who is 16 months old, and Andrew "Drew" Williams, born July 6, 1995.

In Memoriam

1920s

PAUL M. ELLWOOD, MD '25, of Oakland, Calif., April 20, 1995, age 95.

EVERETT S. KING, MD '26, of Lakeland, Fla.

ROY E. BRACKIN, MD '29, of Oskaloosa, Iowa, December 24, 1994.

JONATHAN HALSTED MURRAY, MD '29, of Lakewood, Colo., February 13, 1993, age 94.

1930s

PETER A. DUEHR, MD '30, of Verona, Wis., December 2, 1994, age 91.

FERDINAND F. SCHWARTZ, MD '30, of Birmingham, Ala., May 20, 1994, age 92.

JULIA LUNDSTROM WIXTED, MD '32, of Phoenix, Ariz., April 26, 1995.

JOHN RUSSELL BRINK, MD '33, of Radnor, Pa., 1994.

CRAIG C. WALES, MD '34, of Youngstown, Ohio, May 9, 1995, age 89.

RALPH L. FITTS, MD '35, of Albuquerque, N.M., June 13, 1995, age 94.

JOHN K. WINTER, MD '35, of Holland, Mich., April 20, 1995.

STEPHEN E. GATES, MD '36, of Conneaut, Ohio, October 26, 1994.

VIDA H. GORDON, MD '34, who helped develop pediatrics as a medical specialty in Arkansas, died July 9, 1995, at age 88.

One of the first pediatricians to launch a private practice in Arkansas, Dr. Gordon helped establish the department of pediatrics at the University of Arkansas for Medical Sciences (UAMS) in Little Rock. In 1954, she helped organize the Arkansas chapter of the American Academy of Pediatrics and served as its president for five years. As the first board-certified pediatric allergist in Arkansas, she established a two-year fellowship program at UAMS in allergy and immunology.

Dr. Gordon was named the 1990 Rush Medical College Distinguished Alumna.



Vida H. Gordon, MD '34, is presented with the 1990 Distinguished Alumna Award by her former student, Roger C. Bone, MD, who was then professor and chairman of medicine at Rush.

IRVING CRAIN, MD '37, of New York, N.Y., May 11, 1995, age 81.

CHAUNCEY HOFFMAN, MD '37, of Johnstown, Pa., April 7, 1994, age 88.

MILTON H. PARTRIDGE, MD '37, of Waynesboro, Pa., November 1994.

FRANK ANKNER, MD '38, PhD, of Edina, Minn., February 12, 1995, age 81.

FRANCIS BROWN, MD '38, of Henniker, N.H., December 17, 1994.

JOHN ANDREW WYNESS, MD '38, of Springfield, Ill., April 4, 1992.

1940s

EBEN STODDARD, MD '41, of Marblehead, Mass., May 10, 1995.

FRANCIS J. QUINCANNON, MD '42, of Harvard, Ill., February 28, 1995, age 77.

1970s

ALVIN LEWIS BREWER, MD '79, of Atlanta, Ga., March 18, 1995, age 48.

1980s

DIANE JUNDANIAN SCHERMERHORN, MD '87, of Palos Heights, Ill., June 1995.

RUSH MD

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 RUSH

Alumni Calendar

DEPARTMENT OF PSYCHIATRY GRAND ROUNDS

Sponsor: Department of Psychiatry. Every Wednesday (except first Wednesday of the month), 10:30—11:30 a.m., September—June, A.B. Dick Auditorium.
For more details, contact Lenore Opasinski, (312) 942-5372.

SLEEP CENTER GRAND ROUNDS

Sponsor: Department of Psychology and Social Sciences. Every Friday, 11:00 a.m.—noon, Sleep Center Conference Room, 218 Rawson.
For more details, contact Rosalind Cartwright, PhD, (312) 942-5440.

PREVENTIVE MEDICINE

GRAND ROUNDS
Sponsor: Department of Preventive Medicine. Every Tuesday, 11:45 a.m., September—June, Claude H. Searle, MD, Conference Center.
For more details, contact Shannon Neuwirth, (312) 563-2064.

DECEMBER 6-8, 1995

Conference: "Neurology for the Non-neurologist"
Sponsor: Department of Neurological Sciences. Various speakers. Swissotel, 323 E. Wacker Dr., Chicago.
For further details, contact Rae Ward, (312) 942-7119.

JUNE 6-8, 1996

Rush Medical College Alumni Weekend '96. Special reunion activities for classes of 1936, 1941, 1976, 1986, 1991.

JUNE 6, 1996

Executive Council Meeting

Social Hour
for Returning Alumni

Benjamin Rush Society
Annual Dinner Meeting

JUNE 7, 1996

Alumni Day (on campus)

Commencement Banquet
Hotel InterContinental
505 N. Michigan Ave., Chicago

JUNE 8, 1996

The Tenth Annual
Frederic A. de Peyster, MD,
Rush Alumnus Lecture: "The
Changing Face of Congenital
Diaphragmatic Hernia."
Sponsor: Rush Surgical Society.
Speaker: Marc Cullen, MD,
President, Rush Surgical Society.
*For details, contact John Cook,
MD, (312) 751-2112.*

Commencement Exercises
for Rush University

Anita Dee II Dinner Cruise
Navy Pier, Chicago



...continued from front page

pay costs in terms of altered work environments, legal liabilities, and lost applicants and students. A survey Nora conducted this year with senior medical students at Rush showed that for 10 percent of the graduates, gender discrimination issues affected their choice of specialties or residencies.

Sexual Harassment in Medical Education

"Students don't need to experience a program directly. Decisions are based on the reputation of a program," she says. Nora shared some of her findings in a presentation on sexual harassment at Medical Grand Rounds during Alumni Weekend at Rush in June.

All residencies and specialties desire to attract the top students — half

of whom, nowadays, are women, says Nora. Therefore, it only makes sense for programs to keep tabs on their environment and make the necessary changes. "It's not just a matter of not being the right thing to do," says Nora. "In today's times, I think it's valuable to demonstrate that sexual harassment doesn't make economic sense."





Two views of the same hand and wrist show where Norian SRS has been injected near the lower end of the radius.

Paste may eliminate pins in fractures

Rush is testing a toothpaste-like substance that mends shattered bones, possibly eliminating the need for surgically implanting pins when treating fractures.

Orthopedic surgeon Mark Cohen, MD, who specializes in treating injuries of the hand, wrist and elbow, injects Norian SRS, a paste made of calcium and phosphate, through the skin into spaces caused by fractures of the wrist. After about 10 minutes, it hardens and becomes as strong as natural bone, holding splintered bones in place and filling in fractures. New bone cells grow into and replace the compound, which disappears as the fracture heals.

"Its potential is that it could eliminate bone grafts and the metal pins, plates and screws we now use to repair fractures," says Cohen, one of 10 principal investigators testing the compound. "With Norian SRS, patients wear casts for two weeks and then a splint." Broken wrists typically require a cast for at least six weeks.

Cohen believes Norian SRS has potential in treating fractures suffered by people with osteoporosis, a disease that makes bones brittle and porous. Nearly half of the 550,000 people who break their wrists every year in the United States have osteoporosis.

Patients in Cohen's study are between 45 and 80 years old and are referred to the study by their physicians. All have suffered wrist fractures near the lower end of the radius, the short outer bone of the arm.

— D. Van

Surgical hope for Parkinson's patients

For most people with Parkinson's disease, the drug L-dopa offers temporary relief from stiffness, slowed gait and uncontrollable tremors. After years of treatment, however, many patients develop complications such as agonizing muscle spasms and periods of severe immobility known as "freezing."

A Rush team is performing a surgery, called pallidotomy, that offers hope when L-dopa fails. Since 1992, nearly 500 Parkinson sufferers worldwide have undergone the surgery, including more than 20 at Rush. It's not a cure, but most patients report a decrease in muscle spasms, freezing, and other undesirable movements — benefits that appear to last years after surgery.

In pallidotomy, a neurosurgeon tunnels a probe deep into a Parkinson's patient's brain and burns away a strip of defective neurons in a region called the pallidum. The technique was developed in the 1950s, but was never widely used because of the risk for devastating complications — paralysis, even death — if healthy brain cells were accidentally destroyed.

Today, pallidotomy is gaining popularity because it can be performed with more precision and less risk, using new imaging techniques that "map" the brain's electrical activity. "We can target and destroy the malfunctioning neurons without harming healthy tissue," says Rush neurosurgeon Richard Penn, MD.

Patients most likely to benefit are those whose drugs are failing them, says Penn. A Rush team led

by Penn and neurologist Kathleen Shannon, MD, are studying the surgery to gain a better understanding of how it alters the brain's nerve circuits.

The researchers are also tracking the long-term benefits of pallidotomy. "Right now, most information on pallidotomy is based on patients' reports, which may be unreliable," explains Shannon, who evaluates patients before and after the surgery.

"When a procedure is this highly publicized, people tend to approach it with great hope. This can influence their perceptions," she says. "Patients who have pallidotomy must be rigorously evaluated to confirm that the benefits they think they're experiencing are real."

— C. Janusz

Less can mean more in lung surgery

Severe emphysema leaves its sufferers struggling for breath and unable to do simple tasks such as taking a shower or walking from the kitchen to the bathroom. Because lung transplants are reserved for patients in their 40s or 50s, older patients with emphysema usually are treated with antibiotics, steroids and oxygen therapy — therapies that often provide little relief.

Now, a lung surgery can help emphysema patients, even those over age 60, breathe more freely. In volume reduction surgery — a procedure offered by Rush and a growing number of medical centers across the country — surgeons remove 20 to 30 percent of the diseased lung. Patients are literally given more room to breathe.

Like balloons, the lungs are elastic. They fill with air and collapse naturally under the weight of the chest wall. Emphysema damages the elastic fibers in the lungs' air sacs, limiting the lungs' ability to deflate after a person inhales. Volume reduction surgery appears to help the lungs deflate.

The surgery works best for patients whose lungs are covered with scattered patches of diseased tissue. "We can operate on the worst patches, allowing the other, less damaged parts of the lung to work at full capacity," says Rush cardiovascular-thoracic surgeon William H. Warren, MD.

Candidates for the procedure include patients with advanced emphysema who have either failed to respond to medications, or require oxygen to breathe. Patients must have quit smoking

at least three months prior to surgery. They must also participate in a six-week rehab program to improve health and stamina.

Warren says the surgery is not a cure for emphysema, but it can improve patients' lung function by as much as 90 percent.

— S. Jeantheau

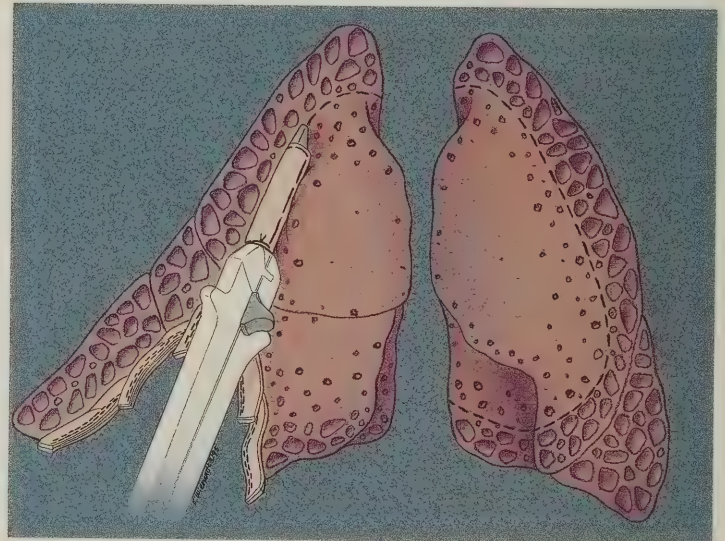


Illustration: Kristen Wienandt

In volume reduction surgery, up to one-third of the diseased lung is removed, allowing the remaining tissue to work at full capacity.

Study links pregnancy and transplant rejection

Women who have been pregnant are more likely to reject heart transplants than are other women and men, a recent study has found.

The link was discovered in research at Rush and 33 other sites that focused on the higher frequency of rejection in women, who make up about 20 percent of heart transplant recipients.

The study found that women who have been pregnant may be more sensitive to exposure to foreign tissue, such as a transplanted heart. This sensitivity may result from previous exposure to antigens

— foreign proteins, such as bacteria and viruses, that stimulate the body to produce antibodies that counteract the foreign invaders. Pregnant women are exposed to antigens that are passed to a fetus from its father.

"Our data suggest that women who have been pregnant may need to be treated differently, perhaps by receiving more immunosuppressive drugs to stop the body from rejecting the transplanted organ," says cardiologist Maryl Johnson, MD, a principal researcher in the study and a member of the Heart Failure and Cardiac Transplant Program of the Rush Heart Institute.

Johnson emphasizes that further studies are needed to determine the exact

reason for the increased frequency of rejection and to determine proper treatments.

The study was performed using the national Cardiac Transplant Research Database, which contains information on more than 3,000 patients who have received transplants since 1990 at 34 institutions nationwide. The database, centered at the University of Alabama, enables participating transplant centers to view other cases to learn more about post-transplant complications and to develop prevention and treatment methods.

— J. Meyers

Yet another reason to eat your broccoli

The most formidable new weapon against lung cancer may be a nutrient found in melons, berries and leafy greens. Researchers at Rush and 24 sites nationwide are studying whether vitamin A offers protection against this deadly cancer.

The five-year study will determine if large daily doses of cis-retinoic acid — the chemical name for vitamin A tablets — prevent second cancers in people who have been successfully treated for early-stage lung cancer.

"These people are considered cured, but they remain at risk for getting a new, or second, lung cancer. The risk of developing a second lung cancer is estimated to be 1 to 3 percent per year for the first five years following curative surgery for lung cancer," explains oncologist Philip Bonomi, MD, who leads the study at Rush.

Research shows that vitamin A also helps prevent second cancers in people who have been successfully treated for head and neck cancer, a disease that closely resembles lung cancer.

The common denominator, says Bonomi, may be smoking. Smoking is blamed for up to 85 percent of all lung cancers and 75 percent of all head and neck cancers.

Smoke, a potent carcinogen, gradually damages the cells in a smoker's lungs, head and neck, making them more likely to turn malignant, explains Bonomi. Researchers suspect that vitamin A somehow prevents these wayward cells from turning cancerous.

If the preventive powers of vitamin A are borne out by research, physicians will have an effective new defense against lung cancer, the single most deadly form of cancer in men and women alike.

But Bonomi is quick to warn smokers that vitamin A is no magic pill. "The best way to prevent lung cancer is still to stop smoking," he says.

— C. Janusz

An aspirin a day saves lives and dollars

Researchers have known for years that a daily dose of aspirin can ward off second heart attacks. A Rush study, however, shows aspirin not only saves lives — it saves money.

Researcher William Elliott, MD, PhD, found that aspirin is more cost effective than four prescription medications: propranolol, timolol, captopril and ramipril. These medications are commonly taken by heart attack patients to reduce their risk for further attacks.

"Aspirin use was associated with an overall savings due to its lower purchase cost and its impressive ability to prevent recurrent heart attacks, which can be dangerous, debilitating and expensive," says Elliott, a physician in the Rush Department of Preventive Medicine.

A year's supply of aspirin, along with one extra doctor's visit to monitor a patient for possible side effects, costs about \$95, the Rush research shows. The other medications range in cost from several hundred to tens of thousands of dollars per year of life saved.

Previous studies show aspirin reduces patients' risk for second heart attacks by about 35 percent — as much as the more expensive prescription medications.

"It may be one of the few preventive therapies, besides immunizations, that saves both lives and money," says Elliott, who cautions that aspirin can cause stomach problems and internal bleeding, and is not an option for all patients. He suggests heart attack survivors talk to their doctors before starting any treatment.

— B. Harfmann

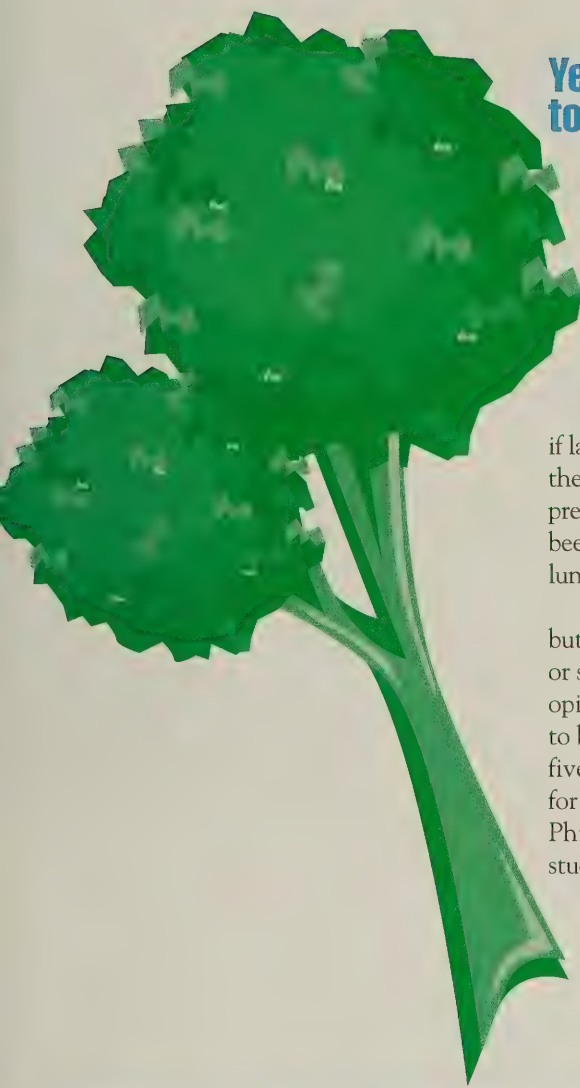




Photo: © Luc Delahaye/Sipa. Sarajevo shelling

HEALING THE SCARS OF WAR

Rush team helps Chicago's Bosnian refugees put violence behind them.

When fighting broke out in the former Yugoslavia in the early 1990s, Bosnian Azra Isovich was working in Sarajevo as a laboratory technician, a job she had held for 15 years. It became impossible for her to stay another year.

Serbian troops had begun to drive away all non-Serbs — including Muslims and people in mixed marriages like Isovich — from Bosnia, which had become independent of what is left of Yugoslavia. Troops arrived at Isovich's lab, refusing to let her return to work, threatening to kill her. She fled to neighboring Croatia, at that time a Bosnian ally.

After a year and a half of waiting in lines for food, Isovich came to the United States as a refugee in 1992. Today, she works in a busy Chicago medical clinic along with Enisa Carkovic, another former Sarajevo resident. The violence in their homeland seems a distant memory

as the two nonchalantly talk about a recent shooting near their northside office.

"It's a piece of cake," says Carkovic, to which Isovich adds, "We know how to duck."

Because of the recent fighting in the Balkans, Chicago has seen an influx of new Bosnian refugees. To help smooth their adjustment, Rush psychologist Abigail Sivan, PhD, trains bicultural workers, like Isovich and Carkovic, who help the new arrivals cope with their adjustment to Chicago.

Sivan was one of eight healthcare professionals from Rush who traveled to the war-ravaged area in 1994 at the request of a special United Nations commission investigating war crimes. The Rush professionals worked alongside a group of lawyers who gathered testimony from people who had been raped and tortured, or had witnessed such acts of cruelty.

"The trauma was different from what I'm used to seeing in my work with victims

of violence," says Sivan. "It's genocide. How do we permit ourselves to know about this crisis and watch without intervening?"

When Sivan returned to the United States after three weeks of intense involvement, she found she wanted to reach out to the Bosnian people here. Because Chicago is the destination of many Bosnian refugees who come to the United States, she knew she had a great opportunity.

"I wanted to offer whatever help I could with their resettlement needs," says Sivan. "The Bosnian refugee community here is not very close knit. I wanted to do something to help people work together."

Some 2,000 Bosnian Muslims who lived in Chicago before the war have built a community center for themselves in suburban Northbrook. But the newer refugees are settling in the Uptown neighborhood on Chicago's north side, closer to the resettlement agencies and clinics that provide them with financial, medical and social support.

Uptown is also the home of the Bosnian Refugee Center where, for the past year, Sivan has held her weekly training sessions. Carkovic, Isovich and some 15 other workers who speak English and Bosnian (Serbo-Croatian) gather to talk about helping new Bosnian arrivals.

At the clinic where they work, Isovich and Carkovic gather basic medical information from incoming refugees at screenings required by the U.S. government. But the two find themselves speaking with new arrivals about everything from Social Security and Medicaid to where to find jobs and buy food.

Some of the other resettlement workers who attend Sivan's 90-minute-long sessions serve as the refugees' case workers. Although Sivan spends a lot of time talking about resettlement problems facing new arrivals, such as finding housing and enrolling children in school, she spends as much time helping the workers, who continue to cope with adjustments themselves.

With a grant from the Illinois Department of Public Health, Sivan will train Isovich, Carkovic and other health screeners to assess the mental health problems of new refugees as part of the medical screenings, so they can be referred for psychiatric help before their problems become overwhelming.

Since April, she and Azra Muftic, a Bosnian social worker Sivan brought on staff at Rush, have been collecting information about the emotional well-being of the new refugees.

Muftic and a Bosnian sociologist, Sahida Ovcina, have interviewed some 200 adults and children at the two medical clinics in the Uptown area. They use interviews to ascertain the refugees' early experiences, as well as their exposure to violence. Questionnaires are used to help the refugees identify their problems.

The data they've gathered, while preliminary, suggests post-traumatic stress disorder is not uncommon among the refugees, says Sivan. About 30 of those interviewed have required referral for counseling or mental health treatment.

Of the 18 states accepting Bosnian refugees, only Illinois is looking at their psychological needs, says Ed Silverman, director of refugee services in Chicago, a branch of the Department of Public Aid.

"War produces two things — cemeteries and refugees. I think it's terribly important for refugees to become aware of their new culture and deal with the extreme trauma they've suffered," says Silverman, who praises Rush's commitment to helping to ease the refugees' process of resettlement.

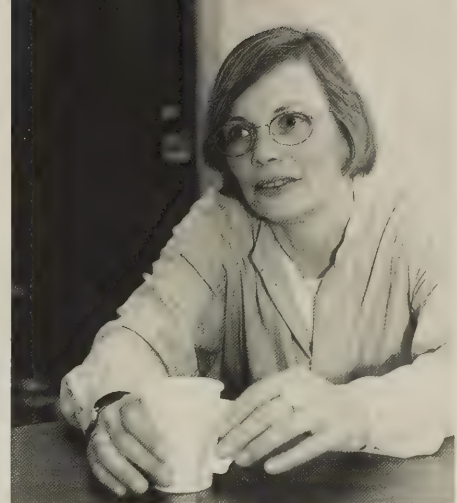


Photo: Eric Werner

Rush psychologist Abigail Sivan, PhD

Sivan's desire to help the Bosnians has blossomed into a deep personal commitment to the refugees. She collects used clothes and furniture for them, identifies possible employment sites and finds people to tutor them in English. In general, she encourages them to look ahead.

"There is no future for them in Bosnia right now. No place to work, no place for their kids to go to school. There's nothing," she says. "Living on public aid in Chicago at least puts them in a country where they'll have these opportunities. There's hope.

"But living as a refugee is not a way to live. Giving people a sense of competence is what's going to give them success." ■

RUSH STAFF GATHER FACTS ON THE CRIMES OF WAR

Wars among Serbians, Bosnian Muslims and Croats date back centuries. But the conflict of the 1990s, marked by flagrant violations of human rights and protections, stirred the United Nations to take action.

In 1993, a special U.N. commission was formed to conduct a fact-finding investigation of war crimes. The organization sought to indict soldiers who committed heinous acts of violence, including rape, murder and torture, in what has come to be called "ethnic cleansing," a euphemism for genocide.

Stephanie von Ammon Cavanaugh, MD, a professor of psychiatry at Rush, was invited by the U.N. commission to lead a healthcare team and accompany a group of lawyers to the Balkan region to collect information on war crimes.

In early 1994, the lawyers began gathering testimony from victims while Cavanaugh's team, including seven other people from Rush, helped victims deal with the strain of reliving their trauma. Because of the complex political situation, team members had to maintain complete secrecy in gathering information from the refugees, to ensure the refugees' safety.

Over four weeks, the team interviewed 82 victims. Half had been raped and tortured, and more than half suffered post-traumatic stress disorder.

"I'd never been in a war zone. You cannot comprehend it. You think you can, but you can't," says Cavanaugh. "It's not just torture and rape. Your home's destroyed, your family's killed, your whole culture's destroyed. That's what war does."

With a MacArthur Foundation grant, Cavanaugh is using data obtained from the United Nations and from the interviews her team conducted to study how wartime experiences lead victims to develop psychological illnesses, such as post-traumatic stress disorder, depression and anxiety disorder. Results from her study will be shared with the U.N. commission in preparation for prosecuting the war criminals.

Despite their hardships, Cavanaugh says that most of the victims have come through well.

"This is a remarkably strong group of people, who through all of this have been able to maintain a sense of humor, concern for others and an incredible sense of family," she says. "The strength of their spirit in the face of adversity is amazing." ■

— S. Jeantheau

A Battle on Two Fronts



While patients wage a daily struggle against rheumatoid arthritis, scientists search for a winning strategy.

The pain became a part of Rita McLeish when she was 41 years old. It crept into her hands as she tended to her family's horses on rainy fall afternoons, a dull throb that slowly invaded her knuckles and fingers. It settled in her hips as she practiced her golf swing at the neighborhood driving range. It attacked her wrists when she turned the doorknobs in her suburban Chicago home.

For the next 20 years, rheumatoid arthritis ravaged her body, the dull pain of its early stages at times erupting in severe waves that forced her to her bed. Now, at age 65, her body is testimony to the disease's scourge: Her hands, wrists and feet are badly deformed. A slight limp tells of the hip and foot surgeries she's endured to repair tattered joints.

"This is not a nice disease," says McLeish. "It doesn't kill you, it just takes everything away."

During the 20 years that Rita battled rheumatoid arthritis, a pair of Rush scientists were waging war against the disease on a very different front. Armed with microscopes, test tubes, and a seemingly endless trail of charts and graphs, Katalan Mikecz, MD, PhD, and Tibor Glant, MD, PhD, DSc, toiled in laboratories in the United States and abroad for effective treatments and a possible cure for this enigmatic disease.

Now, after more than two decades of trying to unravel the mysteries of rheumatoid arthritis, the husband and wife team believe they may have reached a breakthrough. The scientists, faculty of the Rush Arthritis and Orthopedics Institute, recently identified an antibody that dramatically reduces joint inflammation in laboratory mice afflicted with symptoms that mirror those of rheumatoid arthritis.

Although clinical trials are not expected to begin before mid-1996, the researchers believe their findings may provide relief for millions who suffer from this chronic and destructive form of joint inflammation.

In the United States alone, more than 2 million people — two-thirds of them

women — suffer from rheumatoid arthritis. In its mildest form, the disease is merely uncomfortable, a nagging stiffness in the joints that doesn't seem to go away. At its worst, however, rheumatoid arthritis causes severe pain and cripples joints, and can damage the heart, lungs, muscles, blood vessels and nerves.

Like McLeish, most rheumatoid arthritis sufferers are first affected in middle age. The disease initially attacks small joints in the wrist, hands and ankles, and usually occurs symmetrically: Pain and swelling in the right wrist, for example, will be accompanied by



Rheumatoid arthritis patient Rita McLeish.

similar symptoms in the left wrist.

The disease causes inflammation of the synovial membrane, a layer of smooth, slippery tissue that lines joints and surrounds tendons. The inflamed tissue causes cartilage and bone erosion, and in advanced stages, bones may fuse.

Experts suspect that rheumatoid arthritis is the result of a malfunctioning and overactive immune system, in which cells and their products that normally protect the body from disease turn and attack it. Just what causes this revolt remains a mystery. It is known, however, that the inflammation that occurs in the joints of rheumatoid arthritis sufferers is the result of a massive invasion of white blood cells, called leukocytes, which attack joint tissue.

Using a unique mouse model that simulates human rheumatoid arthritis, the Rush

researchers have found that a cell surface molecule plays a crucial role in maintaining inflammation in joints.

The molecule, called CD44, is found on the surface of synovial cells, which live in the soft tissue surrounding cartilage and bone in joints.

The primary function of CD44 is to anchor a sugar-like molecule, called hyaluronan, to the surface of the synovial cells, according to the scientists. The sticky hyaluronan, when anchored to CD44, traps water in the joint tissue.

When leukocytes invade the joint tissue, CD44 and hyaluronan are over-produced, and large amounts of water accumulate in the joints, causing swelling. The invading leukocytes, while sticking to hyaluronan with CD44, cause extensive tissue damage, according to the researchers.

The scientists found that an antibody, called IM7, strips CD44 from the surface of synovial cells and leukocytes. When CD44 is removed, the hyaluronan and water disappear from the tissue, and the swelling decreases. Leukocytes, when stripped of CD44, lose their ability to stick to the tissue, according to the study, which was published in the June 1 issue of the scientific journal *Nature Medicine*.

"When you eliminate the swelling, you also abrogate the gathering of inflammatory cells, thus preventing joint damage," says Mikecz. Working with Mikecz and Glant on the study were Frank Brennan, PhD, and

Jonathan Kim. All four are faculty of the departments of Orthopedic Surgery and Biochemistry.

When tested on mice afflicted with rheumatoid arthritis-like symptoms, low amounts of the antibody caused joint swelling to decrease dramatically. In fact, it produced a visible reduction in joint thickness within 24 hours of a single injection. The animals, according to the research, showed obvious signs of pain relief and quickly resumed their normal cage activities. The study also found that after two weeks of daily injections, all swelling had subsided and the joints were free of leukocytes.

The results seem to indicate that the treatment provides long-term relief of pain and swelling: Some mice had no further treatment and experienced no recurrence of symptoms. And, most promising, the treatment saved the mice from joint

deformities that inevitably result from long-term inflammation.

The researchers emphasize that while the antibody relieves the symptoms of rheumatoid arthritis, it is not a cure. Because rheumatoid arthritis is suspected to be caused by an overactive immune system, patients remain susceptible to future attacks by the disease. And while the antibody reduces fresh swelling in joints, it cannot reverse deformity in joints that have already been damaged.

"This therapy would help until a patient's immune system becomes activated again," Glant says. "Maybe it would work for one week, maybe for one year, maybe for 10 years. It would probably have to be used again and again during inflammatory episodes."

The team expects that results of clinical trials will be similar to those of the laboratory tests. Trials are expected to begin in mid-1996 and last several years. In preparation, the team is now studying the antibody's affect on human cells in the laboratory, purifying more antibody and examining human safety issues, although studies indicate the treatment is free of serious side-effects, Mikecz says.

If human trials produce results similar to those found in the laboratory study, the antibody could indeed prove to be a breakthrough. While a variety of treatments are currently available for those suffering from the disease, none produce such dramatic benefits.

With current treatments, best results are achieved if the disease is fought on two fronts, according to Robert Katz, MD, of

the Rush Arthritis and Orthopedics Institute. To attack inflammation and pain, doctors recommend non-steroidal drugs like aspirin, ibuprofen, and naproxen, and, in severe cases, corticosteroids like prednisone. To help limit joint destruction and deformity, doctors prescribe drugs that can attack the cells causing joint damage. One of the



Researchers Tibor Glant, MD, PhD, DSc, and Katalin Mikecz, MD, PhD.

most common is methotrexate, an immunosuppressant that in higher doses is used in cancer treatment.

Many of today's treatments, however, carry potentially harmful side-effects. Methotrexate, for example, can lead to major complications like liver damage and, in some cases, lung disease. Prednisone and other corticosteroids can cause marked bone loss, cataracts, weight gain and high blood pressure.

Treating the disease at its onset is important to help reduce the chance of complica-

tions like severe deformity, according to Katz.

Rita McLeish, like many rheumatoid arthritis sufferers, initially ignored the dull pain that warned of a potentially serious problem. "I didn't want to admit there was anything wrong," she says now. "I just hoped it would go away."

Joint deformity is common, however, even among those who are treated in early stages. As many as 50 percent of rheumatoid arthritis patients suffer some permanent disability from the disease, despite proper treatment, and 5 to 10 percent are eventually severely disabled. Many patients, like McLeish, require surgery to repair joints that have become deformed, even though the disease has ceased activity.

Eight years after being diagnosed with the disease, McLeish had her left hip replaced. Nine years later, her right hip was gone, too. She has had the toes of both feet straightened and the metatarsal heads — the "knuckles" on the feet — removed. She has considered having her badly deformed hands straightened, but sees little point. "They'd just go back to where they are now," she says.

"There's nothing holding the joints together."

Katz says that while recent medical and surgical advances mean that fewer rheumatoid arthritis sufferers become disabled, improved treatments are needed.

"We've done a great job in terms of medications and joint replacement and other surgeries, but we really need to prevent joint destruction better than we can now, to give these people a better

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TINY MODEL HELPS SCIENTISTS UNRAVEL BIG MYSTERY

In short, they built a better mouse model.

Drs. Tibor Glant and Katalin Mikecz recently were awarded one of arthritis research's highest honors for developing a mouse model that closely simulates human rheumatoid arthritis. The Rush researchers, along with Edit Buzas, MD, a colleague at the Medical University in Debrecen, Hungary, were presented with the Carol Nachman Prize at a ceremony on May 5 in Wiesbaden, Germany.

The mouse model was discovered almost by accident, Glant admits. The scientists were attempting to generate antibodies in mice by injecting them with human proteoglycans, a major component of cartilage. While generating antibodies, however, they also induced arthritis.

"One strain of mice developed arthritis. The arthritis was very similar — almost identical — to human rheumatoid arthritis," Glant says. "We were completely shocked. We began to immunize

similar mice with different types of proteoglycan, but only human proteoglycan induced arthritis."

The team concluded that the genetic background of this strain of mice was similar to that of patients with rheumatoid arthritis, making the mice an excellent study model. Over the past 40 years, researchers have developed about 15 different models in an attempt to simulate the disease, Glant says.

"Experimental animal models are essential to our understanding of the disease," Glant says. "We need animal models because we cannot do experiments in patients."

Glant and Mikecz, along with other scientists, are using the model to search for potential treatments. They are also looking for a gene that controls the disease, which could lead to a cure.

Says Glant, "If we find a gene in this mouse system, we can make a correlation to candidate genes in humans." ■

— J. Meyers

NURSE PRACTITIONERS TAKE CARING TO A NEW LEVEL ■ by Denise Van

DRAMATIC CHANGES IN THIS COUNTRY'S HEALTHCARE SYSTEM ARE GIVING NURSES OPPORTUNITIES THEIR PREDECESSORS ONLY DREAMED ABOUT.

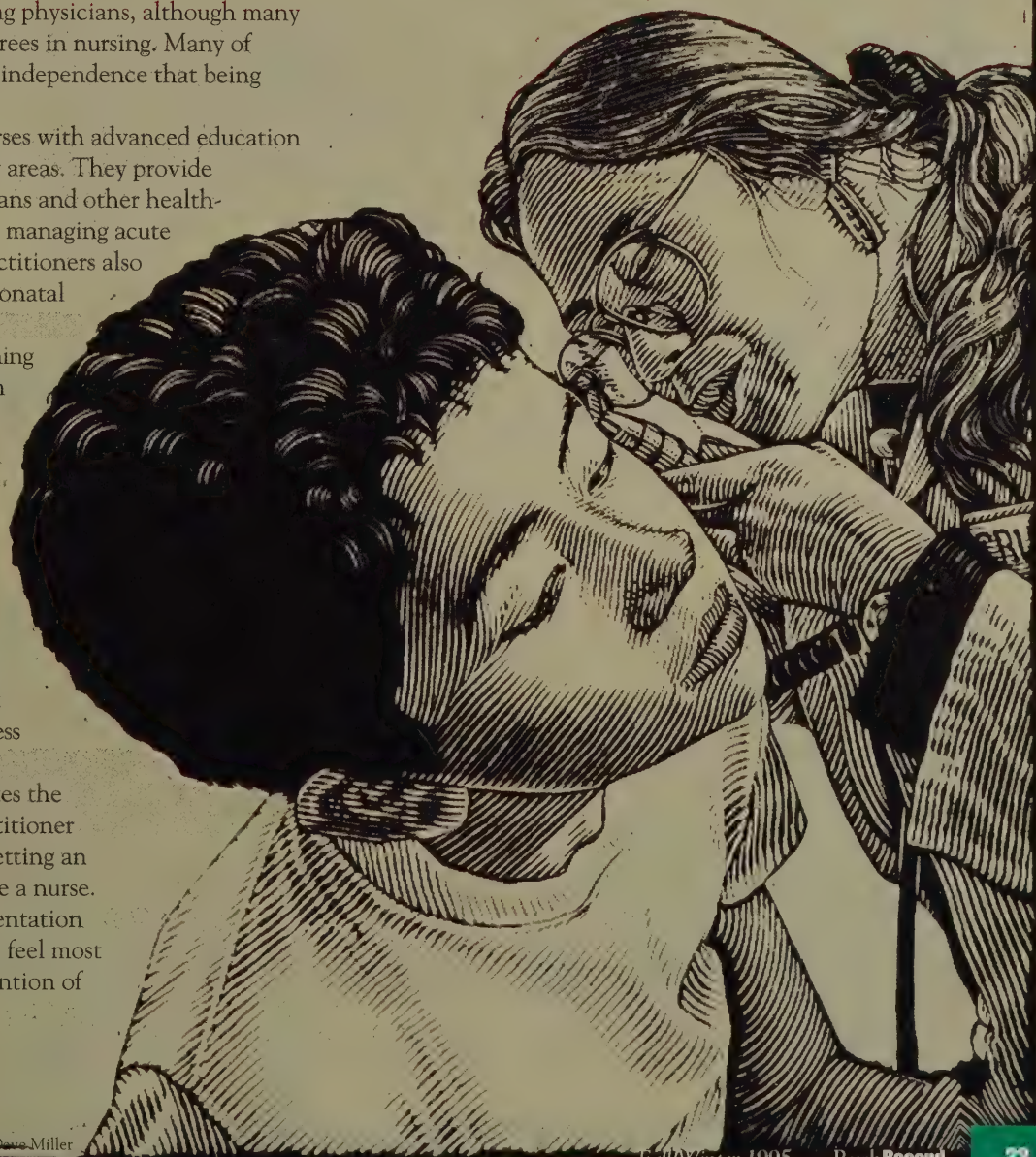
Nurses aren't dreaming about being physicians, although many of them are getting doctoral degrees in nursing. Many of them are also drawn toward the independence that being a nurse practitioner offers.

Nurse practitioners are registered nurses with advanced education and clinical training in medical specialty areas. They provide direct patient care, working with physicians and other health-care workers to provide primary care and managing acute and chronic health problems. Nurse practitioners also provide specialty care in such areas as neonatal intensive care and anesthesia.

One thing they're not doing is abandoning the focus that brought them to the career in the first place. In fact, nurses who choose to add higher levels of education and clinical skills to their portfolios continue to focus on what first drew them to nursing: caring for people.

"Most nurses don't want to become physicians," says Lois Halstead, PhD, RN, associate dean and director of academic services in the Rush College of Nursing. "Nurses care about the person, not just the disease. They are concerned about illness as a part of the patient's life."

Arlene Sperhac, PhD, RN, coordinates the College of Nursing's pediatric nurse practitioner program. She says she once considered getting an MD, but thought, "No, I really want to be a nurse. I liked patient care, and I believe the orientation of nursing is more in keeping with what I feel most strongly about — health, wellness, prevention of illness, achieving optimal function."





Neonatal nurse practitioner Karen Kopischke, ND, RN, soothes an infant having light therapy in the Rush neonatal intensive care unit.

Nurse practitioners work with patients of all ages, and they work everywhere — in urban and rural settings where they increase the access to medical care of people who may not have traditionally been able to get health care, in community and public health centers, hospitals, industry, HMOs, nursing homes, hospices and home healthcare agencies. Many are faculty members in nursing schools and colleges.

Julie Marfell, ND, RN, is a Rush College of Nursing faculty member who teaches both graduate and undergraduate nurses. She is also a primary care nurse practitioner who works in occupational health at the University of Illinois and in a Chicago Department of Health pediatrics clinic in the city's mid-north Uptown neighborhood.

At the clinic, Marfell sees children who are sick with colds and minor childhood diseases. She monitors the health and development of her small patients, making sure their immunizations are up to date and that they are screened for problems such as anemia and high lead levels.

At University of Illinois, she gives pre-employment physicals and evaluates injuries, often after ordering and interpreting tests such as X-rays. "Traditionally, doctors did these things," says Marfell. "But about 10 years ago, the U of I began using nurse practitioners."

In both jobs, Marfell works with physicians, referring patients with special problems to them.

"I've studied in depth what may be only touched upon in undergraduate nursing programs," she explains. "I've been educated to make clinical decisions and I have a greater responsibility to make those decisions."

What's the difference, then, between a physician and a nurse practitioner?

"The primary difference is the degree of independence each has," says Lois Halstead. "Doctors have more. But there is overlap. Nurse practitioners don't engage in all the treatments that a doctor would, although you can't separate the two jobs by activity alone."

Laws regulating the way nurse practitioners practice nursing, and the amount of independence they have in doing their work, vary from state to state. Some state medical societies have welcomed them onto healthcare teams. Others have not.

In some cases, the activities of physicians and nurse practitioners blur. "For example, a nurse practitioner in Alaska may be more independent than one in a big city because there's no easy referral to a physician," says Halstead. "The same could be true of a family practice doctor in Alaska, who may not be able to refer a patient to a cardiologist."

Although nurse practitioners are not going to replace physicians, she says, some populations, such as those in remote and rural areas, may be better served by nurse practitioners.

Says Whitney Addington, MD, director of the Rush Primary Care Institute, "Nurse practitioners are particularly effective in assessing the health status of patients, as relative to their families and communities. Physicians are preoccupied with the biomedical model and less capable of dealing with the social issues, which are equally or more important in determining the onset, severity, care and management of disease."

Nurse practitioners and doctors are not interchangeable, although in some

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A leader in educating nurse practitioners

Rush has been educating nurse practitioners for 30 years, beginning with a six-month associate program for RNs who wanted to be community health nurses. When the College of Nursing was formed in 1972, the special program became a master's level course of study. Today, the master's course offers practitioner preparation in pediatric, gerontology, anesthesia, acute care and neonatal critical care nursing. Graduates take certifying exams in the areas of their specialization. Classes focus on the biological and behavioral sciences and their applications to nursing administration, practice,

education and research.

In 1989, the College began offering the doctor of nursing (ND) degree program because it had become clear that there was a need for nurse practitioners who could take leadership and management roles in healthcare delivery. The doctor of nursing degree prepares nurses to integrate the roles of teacher, consultant and manager of clinical practice. In addition to the specialty areas offered at the master's level, the ND program offers preparation in family health and genetic health nursing. Rush is one of only three nursing colleges in the United States that offer the ND degree. ■

— D. Van

ACTIVIST FOR THE POOR RECEIVES RUSSE AWARD

Whitney Addington, MD, director of the Rush Primary Care Institute and president of the Chicago Board of Health, has been awarded the prestigious Henry P. Russe, MD, Award for Exemplary Compassion in Health Care.

Addington is the third recipient of the award, established by the Chicago Institute of Medicine in honor of Russe, a former Rush Medical College dean. The award, presented at Rush University commencement each June, recognizes physicians who display humanitarianism and intellectual vigor in medicine.

Addington has worked throughout his career to provide quality health care to the poor, his colleagues say. He has been the driving force behind several innovative programs, including a system to deliver tuberculosis treatment to residents in Chicago's poorest neighborhoods.

Addington's commitment to providing medical care to all members of society took root when he was a Northwestern University medical student, said Leo M. Henikoff, MD, president and CEO of Rush, in a speech announcing the award. Performing rotations at Cook County Hospital, Addington was deeply moved by the overwhelming problems faced by the city's poor.

"This youthful idealism did not pass, but rather became the impetus for his life's work," Henikoff said.

Addington completed a fellowship in pulmonary medicine and earned a master's

degree in public health before joining the staff at Northwestern Memorial Hospital.

After being named chief of pulmonary medicine at Cook County Hospital in 1973, Addington built a mobile medical care team that visited poverty-stricken areas to deliver TB pills. The system eliminated the need for Chicago's Municipal Tuberculosis Sanitarium, which at one time had housed 1,500 TB patients. The mobile system is now routinely recommended for TB by the Centers for Disease Control.

In 1985, Addington chaired the Task Force on Health Care for the Poor for the Metropolitan Planning Council. His work there led Chicago Mayor Richard M. Daley to name him chairman of the Chicago Board of Health, the policy-making board for the city's Department of Health.

As the city faced a resurgence of TB, Addington oversaw the development of a computerized patient tracking system that ensures that wherever a patient is seen, healthcare workers have treatment records at their fingertips.

Addington joined Rush in 1993 to head the Primary Care Institute and retrain in generalist medicine. He continues to work to provide health care for the poor, and most recently spearheaded the design for an Institute satellite office in Homan Square, a development in the impoverished North Lawndale community.

Says Pastora San Juan Cafferty, Russe's widow and a Rush trustee, "Dr. Addington is a social activist for the most vulnerable of our society."
— J. Meyers

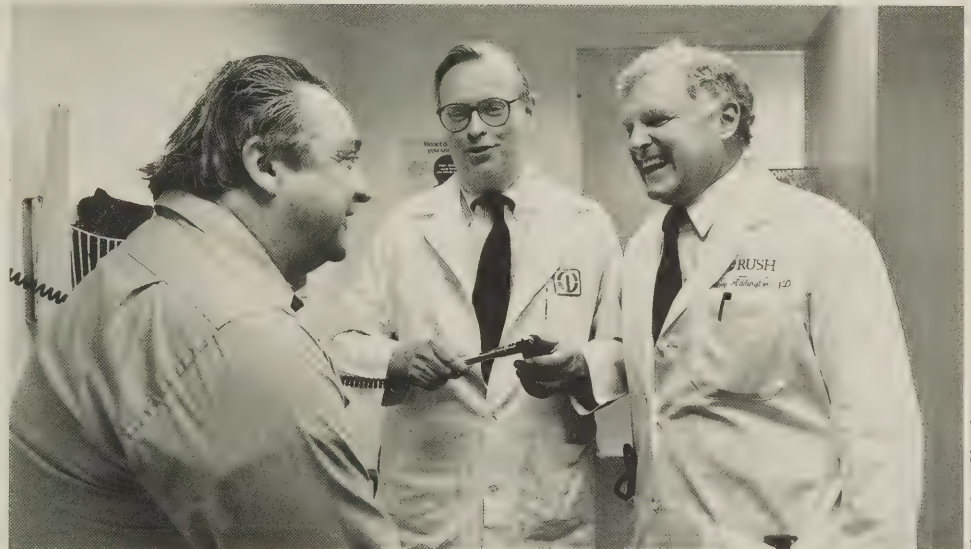


Photo: Jean Clough

Whitney Addington, MD, right, shown with C. Anderson Hedberg, MD, and a patient, received the prestigious Henry P. Russe, MD, award.

THREE NEW TRUSTEES NAMED TO BOARD

William M. Goodyear, Perry R. Pero and John D. Bowlin have been elected to the Medical Center's Board of Trustees.

Goodyear is chairman and chief executive officer of Bank of America, Illinois, a subsidiary of Bank of America, where he serves as group executive vice president. Pero is senior executive vice president and chief financial officer of Chicago's Northern Trust Corporation and its principal subsidiary, the Northern Trust Company. Bowlin is president and chief operating officer of Kraft Foods, Inc., the nation's largest food company.



William M. Goodyear



Perry R. Pero



John D. Bowlin

FOUR NAMED TO ENDOWED CHAIRS

Four appointments to endowed chairs at Rush University were recently announced.

Maria Rosa Costanzo, MD, was named to the John H. and Margaret V. Krehbiel Chair of Cardiology; Michael D. Tharp, MD, was named to the Clark Wylie Finnerud, MD, Chair of Dermatology; Gunnar B.J. Andersson, MD, PhD, was named to the William A. Hark, MD – Susanne G. Swift Chair of Orthopedic Surgery; and Kenneth J. Tuman, MD, was named to the Max S. Sadove, MD, Chair of Anesthesiology.

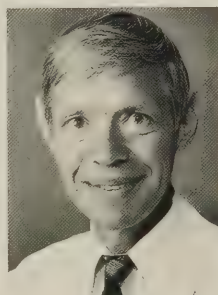
Costanzo is medical director of the Heart Failure and Cardiac Transplant Program in the Rush Heart Institute. Internationally known for her work in heart failure, Costanzo has published more than 150 scientific articles. She joined the Rush faculty in June 1994.



Maria Rosa Costanzo, MD



Michael D. Tharp, MD



Gunnar B.J. Andersson, MD



Kenneth J. Tuman, MD

Tharp joined the Rush medical staff in September 1995 as chairman of the Department of Dermatology. The author of numerous scientific papers, Tharp is nationally recognized for his research on the role of mast cells in skin diseases, and on diagnosis and treatment of hives.

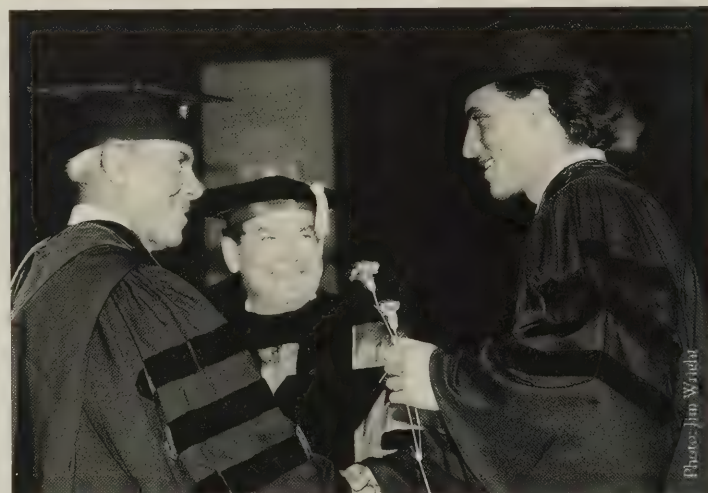
A member of the Rush faculty since 1985, Andersson was appointed chairman of the Department of Orthopedic Surgery in September 1995, having served as acting chairman since 1994. He has published extensively, and his research on spinal conditions and occupational biomechanics has received international acclaim.

Tuman is vice chairman of the Department of Anesthesiology. A member of the Rush faculty since 1984, Tuman's research in cardiovascular anesthesia and anesthesia critical care has earned him and his department international reputations.

GRADUATION KEEPS HEALTH CARE IN THE FAMILY

Nearly 400 graduates walked across the stage of Medinah Temple during Rush University commencement ceremonies June 10. For some, it was a day to celebrate a family tradition in health care. Rush Medical College graduate Christopher Najafi, MD, right, was welcomed into the medical profession by his father, Hassan Najafi, MD, left, chairman of cardiovascular-thoracic surgery at Rush, as Medical Center President Leo M. Henikoff, MD, looked on.

Rush University awarded 393 degrees, including 117 in the College of Medicine, 185 in the College of Nursing, 82 in the College of Health Sciences, and nine in the Graduate College.



From left: Hassan Najafi, MD; Leo Henikoff, MD; and Christopher Najafi, MD.

NEW MEDICAL AND NURSING STAFF OFFICERS ELECTED

New officers for the 1,450-member medical staff and the 1,536-member professional nursing staff assumed office July 1. The medical staff officers are: president, Charles F. McKiel Jr., MD, professor and chairman, Department of Urology; president-elect, Jacob H. Fox, MD, professor and chairman, Department of Neurological Sciences; secretary, Keith W. Millikan, MD, assistant professor, Department of

General Surgery; and treasurer, Vesna V. Skul, MD, assistant professor, Department of Internal Medicine.

Professional nursing staff officers are: president, Gwen Bohlke, RN, senior clinical nurse, AIDS unit; president-elect, Herbert D. Sanders, RN, clinical nurse coordinator, surgical step-down unit; secretary, Liz Krch-Cole, RN, senior staff nurse, psychiatric nursing; and treasurer, Sally Fitzgerald Mydill, RN, staff nurse, psychiatric nursing.

CYSTIC FIBROSIS *cont.*

John's chances for a longer life are improving, says pediatric pulmonologist Raezelle Zinman, MDCM, who recently joined the staff as associate director of the Cystic Fibrosis Center.

"When the disease was first recognized back in the 1950s, it meant a death sentence by age 5," she says, adding that the average life expectancy for people with cystic fibrosis is now 29 years and gradually rising.

"Today, 34 percent of CF patients are over 18 and leading productive lives," she says.

Lloyd-Still and Zinman say many factors have helped increase the odds. New therapies are aimed at treating the infections, decreasing the irritation and thinning the secretions in the lungs of cystic fibrosis patients. Researchers at Rush are studying new ways to improve drug delivery to patients' lungs.

In 1989, researchers isolated the gene that causes cystic fibrosis, bringing a cure for the disease into view. The Weyland family, who have helped raise more than

\$12,000 by holding fund-raisers to benefit cystic fibrosis research, are cautiously optimistic that a cure will be found soon.

"Johnny enjoys doing all the typical kid things and he hasn't let his condition stop him," says his father, John. "He loves sports, video games and fishing. We try not to ask ourselves, 'What's it going to be like 20 years from now?' We live for the present." ■

NURSE PRACTITIONERS *cont.*

cases, they do see the same patients, says Halstead. "When they co-manage a case load, resources are often better utilized."

While salaries of nurses with bachelor's degrees start at \$33,000, those of master's level nurses in Chicago may start at about \$50,000, says Halstead. "An experienced nurse practitioner may get \$60-\$70,000, which is about what family practice physicians who work for HMOs earn.

"But this isn't nursing salaries going up," cautions Halstead. "It's medical salaries going down."

Although the trend toward cutting healthcare costs through managed care systems like HMOs is making the nurse practitioner field attractive right now, Arlene Sperhac believes another factor

is equally important. "People want quality care and they want to be partners in their health care," she says. "They want someone to listen to them and give them information — two things that nurse practitioners do very well. Providing information has always been a part of the nursing orientation."

Although many nurse practitioners may be in management positions in HMOs, nursing homes, clinics and colleges, they, like physicians, must continue to exercise their skills with patients. "They have to practice nursing," says Iris Shannon, PhD, RN, associate professor in the Department of Community Health Nursing. "In nursing, the relationship between practice and skill is the important thing." ■

MARCA BRISTO *cont.*

people to stay put on Social Security or welfare. Seventy percent of disabled persons of working age are unemployed."

Marca Bristo says, "I want to get the world to define us all as normal, then programs and services will respond to the whole range of people."

That's why, she says, the ADA is so important. "In addition to mandating accessibility for the disabled, the law makes a visceral impact as a symbolic demonstration that the United States accepts that disabilities are normal and that policies and programs have to be changed based on that view."

Access Living offers information and referrals, peer counseling, skill training and advocacy to disabled people. Special programs include investigations of unfair housing practices as they relate to the disabled, consultations with businesses and governments on accommodations for the disabled, and management of personal assistants who help disabled people live independently. A program unique to Access Living trains domestic violence counselors to deal with the problems of abused disabled women.

Married for eight years to Bob Kettlewell, an administrator for an Illinois congresswoman, Bristo is the mother of Sammy, 7, and Madeline, 5. She uses a nonmotorized wheelchair. "It gives me cardiovascular and physical exercise," she explains. "I have to drive a lot in my job and it's easier to find parking with a collapsing chair. I use what makes the most sense."

A no-nonsense kind of woman, Marca Bristo is going to continue to challenge the way the world has looked for too long at disabled people. She's gearing up to fight proposed congressional cuts in welfare and Medicaid payments. "Most of the money in Medicaid supports severely disabled and elderly people," she says. She's afraid proposed cuts will jeopardize the movement to home-based care for the disabled, forcing many individuals who now live independent lives into institutions.

This fight and the ongoing struggle for freedom for disabled people to direct their own lives intrigues and motivates Bristo. "I find a degree of momentum in adversity," she admits. "It may take 10 or 20 years, and it may be painful, but the fight will strengthen

the disability community. My desire is for freedom. That means being treated like everybody else." ■

ARTHRITIS *cont.*

quality of life," he says.

Despite the damaging effects of the disease, McLeish has remained fairly active. She attributes that to the excellent and compassionate treatment she received at Rush over the years.

"I wasn't going to let the arthritis stop me from enjoying life," she says. "I'm lucky, because I am stubborn and I got the best care I could get."

McLeish, who tries to stay abreast of current research into rheumatoid arthritis, says that effective new treatments would be a blessing for those battling the disease.

"For me, the damage has been done," she says. "My hope is with the young people. I hope that they won't have to fall apart, because that's what happens to you. You just fall apart." ■



Photo: Jean Clough

Six-year-old cystic fibrosis patient John Weyland, upper right, with his best friend, Ben Pacey. Thanks to aggressive treatment, John can play like a typical boy (see story, page 11).

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